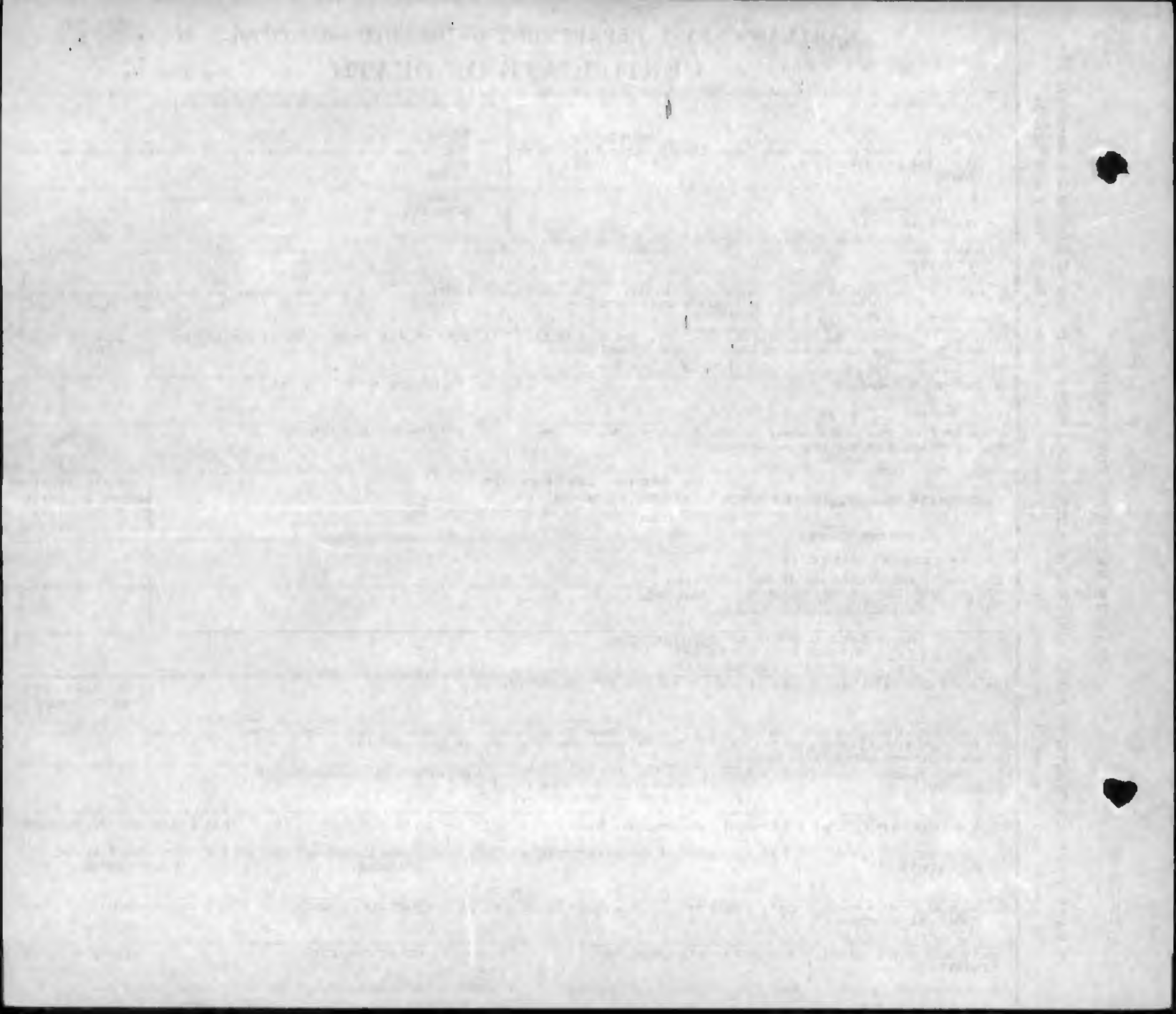


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **579**
9397 Item 11 Film C188 11-10-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. **38**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>...</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <i>Balto. City 3401-4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Collegis Manor</i>				STREET ADDRESS (If rural, give location) <i>Green Mount Ave.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>Oct. 31 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Widow</i>		8. DATE OF BIRTH: <i>May 13, 1872</i>	
9. AGE last birthday: <i>83</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Physician</i>		11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Wm. J. Schultz</i>				14. MOTHER'S MAIDEN NAME: <i>Louise Coleman (?)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <i>None</i>		17. INFORMANT & ADDRESS: <i>Dr. Ronald J. Alexander - 1000 W. ...</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Pulmonary embolus</i>						<i>minutes</i>	
ANTECEDENT CAUSE (B) <i>Thrombophlebitis of legs</i>						<i>one mon</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cerebral arteriosclerosis</i>						<i>yes</i>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March, 1955</i> to <i>present</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>10/27</i> , 19 <i>55</i> , and that death occurred at <i>3:00 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Emmet C. Brown Jr.</i>		ADDRESS <i>1101 N. Calvert St</i>		DATE SIGNED <i>11/1/55</i>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		DATE THEREOF <i>Nov 12/55</i>		NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>		LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>11/1/55</i>		REGISTRAR'S SIGNATURE <i>G.W. Hedrick</i>		24. FUNERAL DIRECTOR <i>Stewart J. ...</i>		ADDRESS <i>13911 ...</i>	



9398

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (In this place) <u>1 yr. 7 mos 2 wks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Point</u> <u>x</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>212 E. Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>G. Sherman Adams</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>10-24-1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>11-13-1873</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>COAL & SCRAP STEEL</u>		11. BIRTHPLACE (State or foreign country): <u>Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Randal Adams</u>				14. MOTHER'S MAIDEN NAME: <u>Polly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>No</u>				16. SOCIAL SECURITY NO. <u>402-01-1653</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Arteriosclerotic Heart Disease</u>						18 mos.	
DUE TO							
(B) <u>Generalized Arteriosclerosis</u>						5+ yrs.	
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 11</u> , 1954, to <u>Oct. 24</u> , 1955, that I last saw the deceased alive on <u>Oct. 24</u> , 1955, and that death occurred at <u>8:30 P M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Louise Frances Woodward</u>				ADDRESS <u>M. D. Spring Grove State Hosp. Catonsville 28, Md.</u>			
DATE SIGNED <u>10-28-55</u>				DATE SIGNED <u>10-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>BELAIR MEMORIAL</u>		LOCATION (City, town, or county) (State) <u>BELAIR, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Nicholas E. Harry</u>		24. FUNERAL DIRECTOR <u>Walter Burke Chasely, Hurdell, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. A.

NOV 1 1955

RECEIVED

9399

09381

Reg. Dist. 46

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Dundalk, Turner's Station</u>			
HOSPITAL, OR INSTITUTION OR STREET ADDRESS <u>Pulaski Hgwy. near Middle River</u>				STREET ADDRESS (If rural, give location) <u>129 Main Street</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u>		(Middle) <u>I.</u>		(Last) <u>ADAMS</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Oct. 27, 1915</u>	
9. AGE last birthday: <u>39</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Night Club</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Iwin Adams</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>World War II</u>				16. SOCIAL SECURITY No.: _____			
17. INFORMANT & ADDRESS: <u>Rosa Adams, 123 Main Street</u>							

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				
<u>983X</u> Immediate cause (a) <u>Asphyxiation</u> DUE TO Antecedent cause(s) (b) <u>strangulation</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>field</u>		21c. (City or town) (County) (State) <u>Pulaski Hgwy. near Middle River Road</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10/15/55 3:15 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Strangled with rope.</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , <u>Homicide</u> <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE <u>William J. [Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>10/16/55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arbutus</u>
LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>Elroy O. Wilson, 2004 Orleans Street</u>		
DATE REC'D BY LOCAL REG. <u>10/19/55</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 25 1945

RECEIVED

9400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Fusting Ave. House in the Pines		STREET ADDRESS (If rural give location) 2726 Oakley Ave.	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
ALICE MURRAY ALBAUGH		Oct. 7, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
female	white	widowed	Dec. 16, 1876
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
78 yrs.		Housewife -rtd	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Maryland			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Richardson		Laura --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Mr. Bryson R. Albaugh - 2726 Oakley Ave.		<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>443X</p> <p>IMMEDIATE CAUSE (A) Myocardial Decompensation -</p> <p>ANTECEDENT CAUSE (B) Ch. Hypertension, Cor. Ar. Disease</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</p> <p>(C)</p>	
19. DATE OF OPERATION:		20. AUTOPSY?	
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-7-55 , 1955, to 10-7-55 , 1955; that I last saw the deceased alive on 10-7-55 , 1955, and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
William K. Galligan		10-8-55	
ADDRESS		M. D. Catonsville-25, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
Burial		Wm. J. Schermer & Sons - Balto	
DATE REC'D BY LOCAL REGISTRAR		REGISTERAR'S SIGNATURE	
		Wm. J. Schermer & Sons - Balto	

MARGIN RESERVED FOR BINDING



09383

STATE DEPARTMENT OF HEALTH

MARYLAND

9411

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13, 14 Film G188 10-25-55 et

1. PLACE OF DEATH- COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Overlea		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Overlea	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4209 Thorncliff Road		STREET ADDRESS (If rural, give location) 4209 Thorncliff Road #6	
3. NAME OF DECEASED (Type or Print) Mr. Daniel H. Alley Sr.		4. DATE OF DEATH (Month) Oct. 17th (Day) 1955 (Year)	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH June 16, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 77 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 216-18-0918	
17. INFORMANT AND ADDRESS Mr. Daniel H. Alley, Jr. 4209 Thorncliff Rd			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) heart failure		chron. myocardiitis	3 yrs
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 16, 1955, to Oct 17, 1955, that I last saw the deceased alive on Oct 16, 1955, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Oct. 19, 1955	NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	LOCATION (City, town, or county) Baltimore, Maryland (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/18/55	W. H. Heston	Leonard J. Ruck, 5305 Harford Road #14	

MARGIN RESERVED FOR BINDING

1

Dr. Rigler
1 W. Overlea Ave.
9 - 11 A.M.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9387				09384			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR		TOWN	
TOWN <u>Fansdowne</u>				TOWN <u>Fansdowne</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1932 Sulfur Springs Rd</u>				STREET ADDRESS (If rural give location) <u>1932 Sulfur Springs Rd</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>Ammond</u>		(Last) <u>Ammond</u>		(Month) <u>Oct</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>April 3 1888</u>	
9. AGE last birthday: <u>67</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Paralel</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>Ammond</u>			
14. MOTHER'S MAIDEN NAME: <u>Ammond</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No.: <u>212 05-2239</u>				17. INFORMANT & ADDRESS: <u>1932 August E Ammond Sulfur Springs</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary thrombosis</u> DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause</u> DUE TO							
stating underlying cause last (c) <u>stating underlying cause last</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Her M Kieffer</u> 1010 Leaden				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct 27 53</u>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10-29-53</u>		NAME OF CEMETERY OR CREMATORY <u>Green Park</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
DATE REC'D BY LOCAL REG <u>Oct 27 53</u>		REGISTRAR'S SIGNATURE <u>Her M Kieffer</u>		24. FUNERAL DIRECTOR <u>Donald W Hubert</u>		ADDRESS <u>1010 Leaden</u>	



CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. ... 41 ...

9374

MARGIN RESET FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY BALTO		MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN DUNDALK	LENGTH OF STAY (In this place) 7 YRS.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 47 NORTH SHIP RD			
3. NAME OF DECEASED (Type or Print)	(First) ABRAHAM	(Middle) GOOD	(Last) BACHMAN
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 10, 1873
9. AGE last birthday 82 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ABRAHAM M. BACHMAN		14. MOTHER'S MAIDEN NAME MARIA GOOD	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. - - - 3	
(If yes, give war or dates of service)		17. INFORMANT WILLIAM M. KELLY	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Coronary Occlusion. Antecedent cause(s) (b) Chronic Hypertension. Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title)	ADDRESS		DATE SIGNED
WILLIAM M. KELLY	100 N. E.		OCT 22, 1955
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	10-25-55	MOUNTAIN VIEW	NORTH MD.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
OCT 19-1955	William M. Kelly	JAMES H.

1955

1955



09386

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9432

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2802 Linsmore Ave.</u>				STREET ADDRESS (If rural give location) <u>2802 Linsmore Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 31 1955</u>			
<u>Ada Rebecca Baker</u>							
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Nov. 15, 1879</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At home</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Benjamin F. Baker</u>				14. MOTHER'S MAIDEN NAME: <u>Almira Krout</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Gladys A. Rosier - 2802 Linsmore Ave.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carelessness of the breast</u>				<u>6 yrs</u>			
ANTECEDENT CAUSE (S) DUE TO <u>with gen. infections</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 10, 1955</u> , to <u>Oct 31, 1955</u> , that I last saw the deceased alive on <u>Oct 24, 1955</u> , and that death occurred at <u>230 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. 7122 Surber Rd</u>		DATE SIGNED <u>11/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/2/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Ellsworth Arnacost - 4600 Liberty Heights Ave. 7</u>	

MARGIN RESERVED FOR BINDING



94'3

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>	55
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>506 Fairmount Ave.</u>		STREET ADDRESS (If rural give location) <u>506 Fairmount Ave.</u>	1

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Mae</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Baker</u>	(Month) <u>Oct.</u> (Day) <u>10</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>May 9, 1870</u>
9. AGE last birthday <u>85</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Stewart</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Harry Baker</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>153 X</u>		
ANTECEDENT CAUSE (S) <u>Ascending Colon</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) <u>Ascending Colon</u>		
(C) <u>of Ascending Colon</u>		<u>3 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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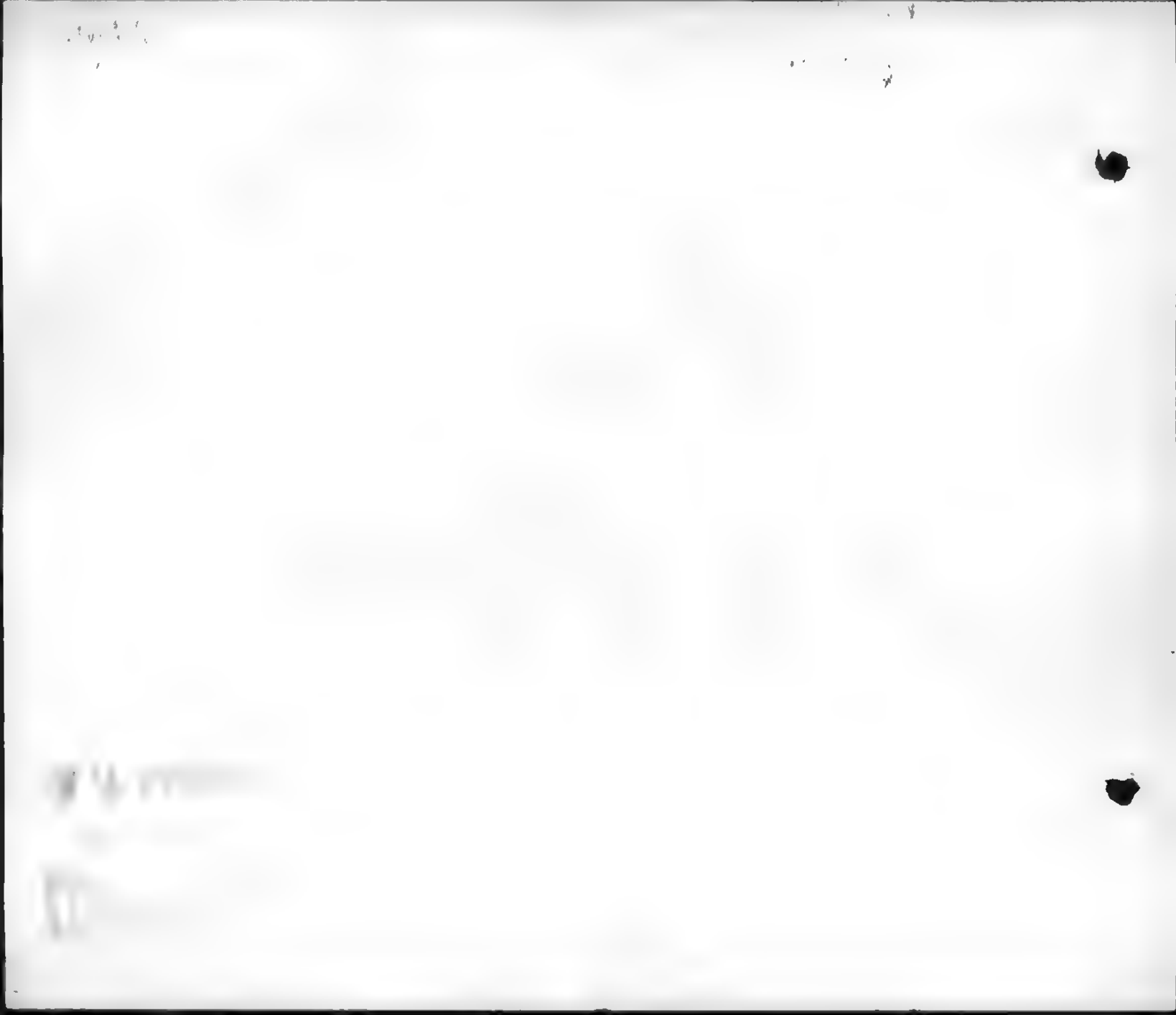
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1955, to Oct, 1955, that I last saw the deceased alive on Oct 10, 1955, and that death occurred at 9⁰⁰ M, from the causes and on the date stated above.

SIGNATURE Charles F. McDonnell ADDRESS 750 York Rd Towson Md DATE SIGNED 10/11/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>Oct. 12, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 12, 1955</u>	REGISTRAR'S SIGNATURE <u>Mabel C Gray</u>	24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING



CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>1</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in Pines 16 Lusting Ave</u>		STREET ADDRESS (If rural, give location) <u>512 Charingcross Rd</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH	
(First) <u>James</u>	(Middle) <u>L.</u>	(Last) <u>Ball</u>	<u>Oct. 14</u> 19 <u>55</u>
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>June 23/64</u>
9. AGE last birthday <u>91</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country): <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Stephen Ball</u>		14. MOTHER'S MAIDEN NAME: <u>Ann Heacon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Grand 512 Charing Rd</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 26, 1955</u> to <u>Oct. 14, 1955</u> , that I last saw the deceased alive on <u>10-14</u> , 19 <u>55</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William K. Gillies</u>		ADDRESS <u>M.D. Catonsville, 28, Md.</u>	
DATE SIGNED <u>10-16-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 17/55</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (Cty., town, or county) (State) <u>Balto-Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/17/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
FUNERAL DIRECTOR <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7 4 0577

200 11 101

10 0 7051

9495

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	MARYLAND	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Talbot
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	Easton
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
LAURA BATTLETT		October 29, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
		Ellen Rigby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)		17. INFORMANT & ADDRESS:	
None		Hospital Reco	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) 491X Broncho pneumonia			3 weeks
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis			
19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Fall of 1954, to present, 1955, that I last saw the deceased alive on Oct 29, 1955, and that death occurred at 6:30 AM, from the causes and on the date stated above.			
SIGNATURE Ernest C. Brown Jr.		ADDRESS DATE SIGNED M.D. 1101 N. Calvert St. Balt. Oct. 30, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10.31.55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 10.29.1955		REGISTRAR'S SIGNATURE Mabel C. Gray	
24. FUNERAL DIRECTOR		ADDRESS Easton, Md.	

MARGIN RESERVED FOR BINDING

A15-10-5

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

100

100



100

9406

CERTIFICATE OF DEATH

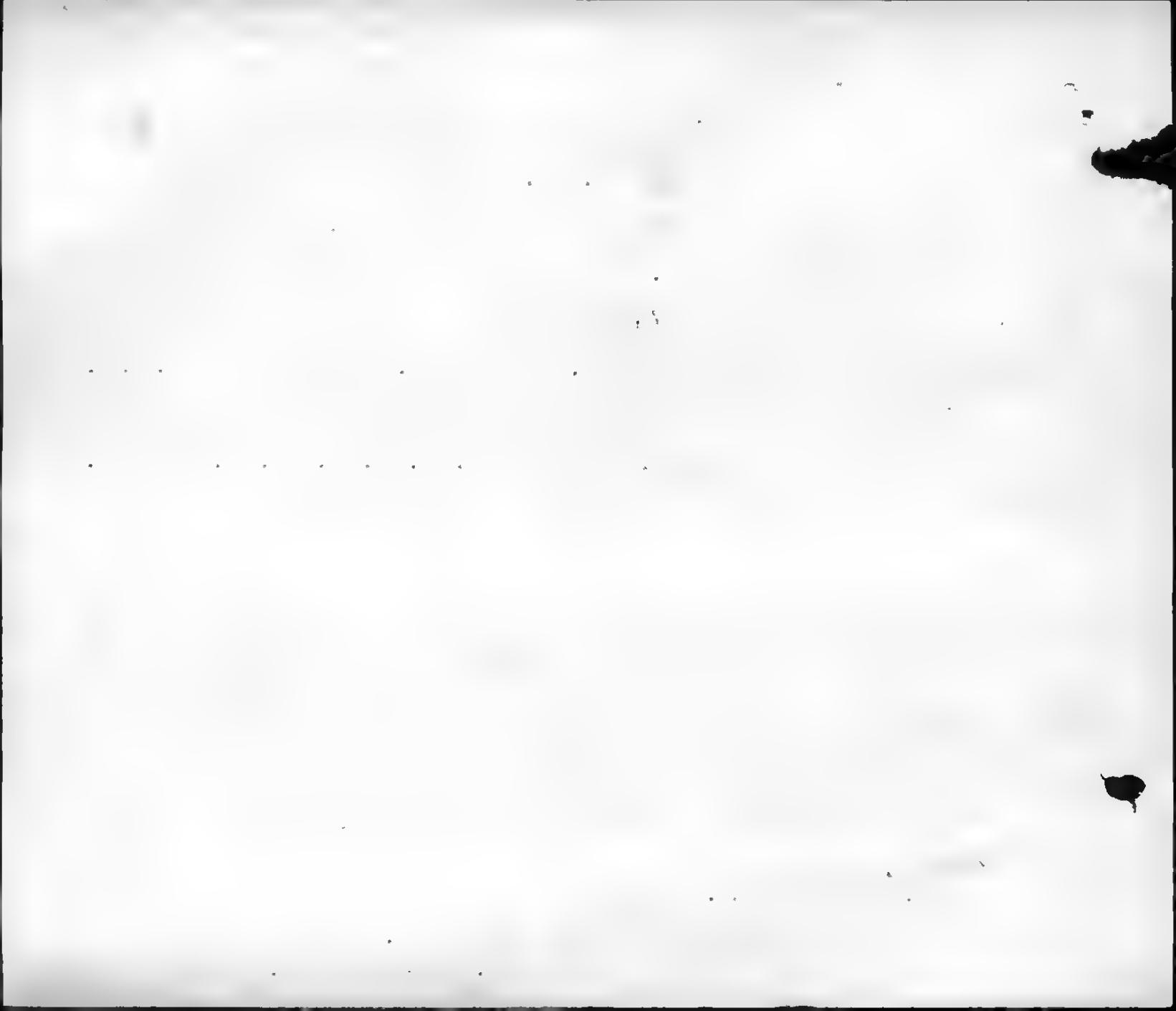
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 5 HRS. 40 M.		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 3817 W. COLDSRING LANE			
3. NAME OF DECEASED: (First) (Middle) (Last) HENRY B. BATES				4. DATE (Month) (Day) (Year) OF DEATH: OCTOBER 17 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 8/8/95	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY: ELECTRICAL CO.		11. BIRTHPLACE (State or foreign country): ARNOLD, N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: THOMAS BATES				14. MOTHER'S MAIDEN NAME: SCARA WEAVER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 220-03-6435			
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) RIGHT CEREBRAL HEMORRHAGE				UNKNOWN			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? 6:00 PM			
22. I hereby certify that I attended the deceased from OCT. 17, 1955 to OCT. 17, 1955 , and that death occurred at 6:00 M. from the causes and on the date stated above. SIGNATURE WILLIAM B. VANDEGRIFT, M.D. ADDRESS M. D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 10-18-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF OCT 20, 1955		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-19-55		REGISTRAR'S SIGNATURE W. B. Vandegrift		24. FUNERAL DIRECTOR ADDRESS WM. COOK-BLIGHT, INC. 6009 HARFORD ROAD, BALTIMORE 14, MARYLAND			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9388

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>51 Halethorpe</u>	<u>8 yrs</u>	<u>Halethorpe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>1801 Woodside Ave</u>		<u>1801 Woodside Ave</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First)	(Middle)	(Last)	
<u>Samuel Selden Baublit</u>		<u>Oct 12 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>M</u>	<u>W</u>	<u>married January 8, 1897</u>	<u>78 yrs.</u>
9. AGE last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>machinist</u>		<u>U S Navy Yard</u>	<u>Beckleyville Md</u>
12. CITIZEN OF WHAT COUNTRY?			
<u>U S A</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Baublit</u>		<u>Samuel Mally Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>218-16-2081</u>	
17. INFORMANT & ADDRESS:			
<u>Mrs Clara A. Baublit</u>		<u>Halethorpe Md</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE		(A) DUE TO	
<u>420.1</u>		<u>Coronary Occlusion Rec.</u>	
ANTECEDENT CAUSE (S)		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>H A. S. C. V. D.</u>	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/15, 1955, to 10/12, 1955 that I last saw the deceased alive on 10/12, 1955, and that death occurred at 8:00 P.M. from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<u>John C. Steacy</u>	<u>Baltimore Md</u>	<u>10/14/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>10/15/55</u>	<u>Long Hill Cemetery Laurel Maryland</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>Oct 15 - 55</u>	<u>Geo. L. M. Shiffers</u>	<u>DeWitt Connelley, Laurel Md</u>

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09392

9407 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>Pikesville</u>				<u>Pikesville</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>508 Sudbrook Rd.</u>				STREET ADDRESS (If rural give location) <u>508 Sudbrook Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>CHARLES H. BAUER, Sr.</u>				<u>Oct. 20, 19 55</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Feb. 3, 1870</u>	
				9. AGE last birthday <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Dairyman</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Joseph Bauer</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Bergen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs. Johanna Bauer - 508 Sudbrook Rd., Pikesville</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>493X</u> (A) <u>Pneumonia</u>						<u>1 week</u>	
ANTECEDENT CAUSE (B): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Abdominal Tumor</u>							
19A. DATE OF OPERATION: <u>—</u>				19B. MAJOR FINDINGS OF OPERATION: <u>—</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1955</u> , to <u>Oct. 20, 1955</u> , that I last saw the deceased alive on <u>Oct 19, 1955</u> , and that death occurred at <u>3 1/2 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howie Salzman</u>				ADDRESS <u>Pikesville 2, Md.</u>		DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>10/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	
LOCATION (City, town, or county) <u>Pikesville, Md.</u>				(State)			
DATE REC'D BY LOCAL REGISTRAR <u>10-27-55</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm. J. Tiekner & Sons - Balto 17, Md.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 45C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09393

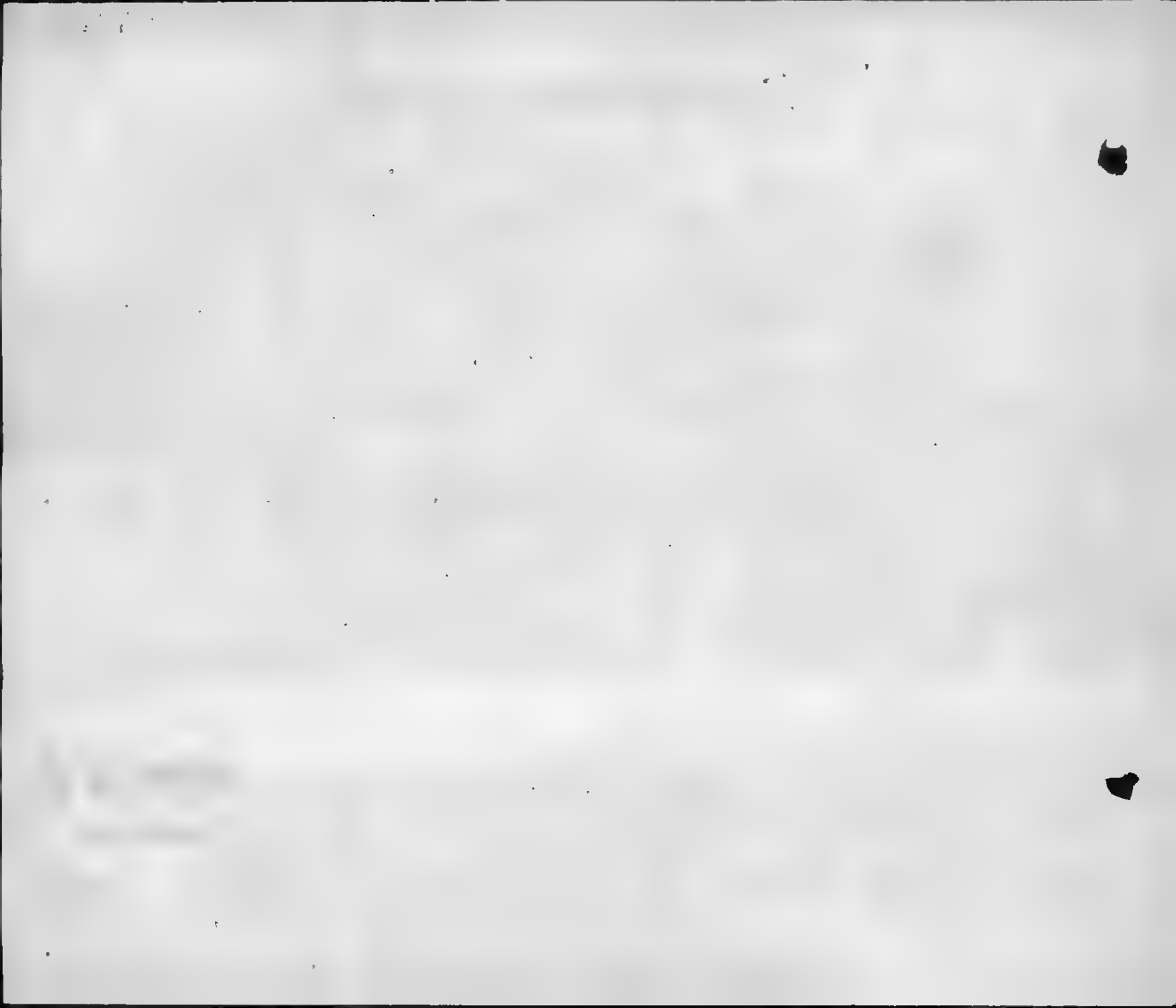
9498

CERTIFICATE OF DEATH

Item 12, Film 4188 11-3-55 et

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>635 North Bend Road</u>				STREET ADDRESS (If rural give location) <u>635 North Bend Road</u>			
3. NAME OF DECEASED (Type or Print) <u>John Bauer</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 26/55 19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 13, 1875</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor of Grocery Store</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Bauer</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS (Signature) <u>Mrs. John Taib, 3512 Alondor</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiac</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>various diseases</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/1/55</u> , 19 <u>55</u> , to <u>10/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>55</u> , and that death occurred at <u>9:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>William Wells</u>				DATE SIGNED <u>Oct. 29, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 29/55</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Oct. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>Victor E. Harrys</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave.</u>	



9479

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY BALTO.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

TOWN ESSEX

HOSPITAL OR INSTITUTION OR STREET ADDRESS

803 PLATUIM AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MO.COUNTY BALTO

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN ESSEX

(If rural, give location)

STREET ADDRESS

803 PLATUIM AVE

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ELIZABETH M BEARMAN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

OCT. 18 19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

SAME

AS ABOVE

RUFUS K BEARMAN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from mm x, 1954, to Oct 18, 1955, that I last saw the deceased alive on Oct 18, 1955, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A11 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3479 Lib. Parkway.

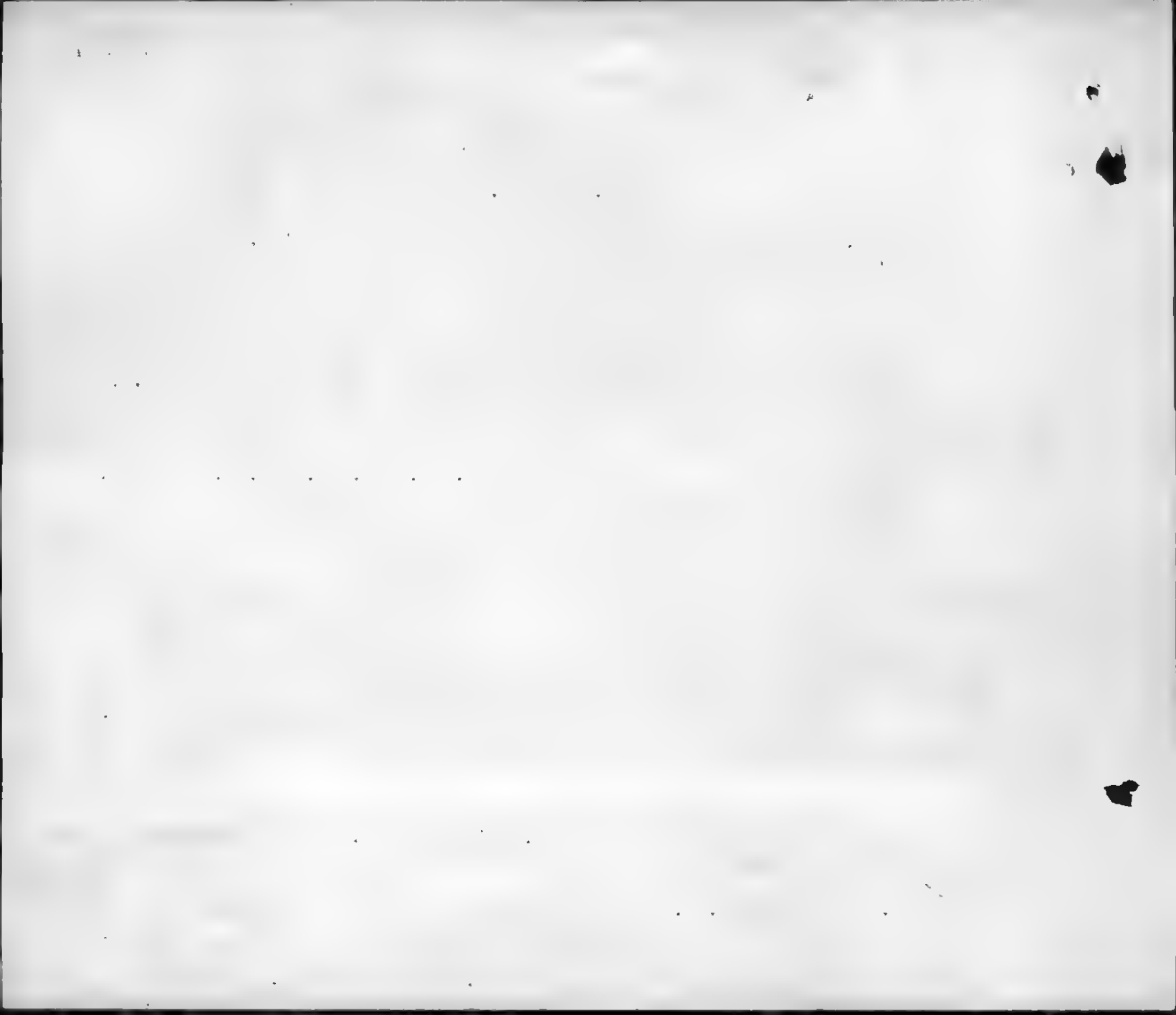
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09395

9410 CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>1</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)			
TOWN <u>FOLT HOWARD</u>		<u>8 hrs. 55 mins.</u>		TOWN <u>BALTIMORE</u>		<u>50</u>	
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
(First) <u>EDWARD</u>		(Middle) <u>(NMT)</u>		(Last) <u>BERNICK</u>		<u>OCTOBER 1 1955</u>	
5. SEX: <u>MALE</u>				6. COLOR OR RACE: <u>WHITE</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>				8. DATE OF BIRTH: <u>12/24/86</u>			
9. AGE last birthday: <u>68</u> yrs.				10. BIRTHPLACE (State or foreign country): <u>SHENANDOH, PENNSYLVANIA</u>			
11. BIRTHPLACE (State or foreign country): <u>SHENANDOH, PENNSYLVANIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>JOHN BERNICK</u>				14. MOTHER'S MAIDEN NAME: <u>JULIA RECTOR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>YES</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>179-09-7580</u>			
17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP. RT. HOWARD, MD.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>OLD AND RECENT INFARCTS OF THE HEART</u>				UNKNOWN			
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from OCT. 10, 1955, to OCT. 10, 1955, that I last saw the deceased on OCT. 10, 1955, and that death occurred at 4:30 PM, from the causes and on the date stated above.							
23. FINAL CREMATION, DATE THEREOF, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>BURNIAL</u> <u>Oct 19 1955</u>				<u>SACRED HEART CEMETERY</u>			
24. FUNERAL DIRECTOR				ADDRESS			
<u>COOK BLIGHT INC.</u>				<u>1009 W. FORT HOWARD, BALTIMORE 14, MARYLAND</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9411

CERTIFICATE OF DEATH

Reg. Dist. No.

093962

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pikesville</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pikesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>6802 Navajo Drive</i>		STREET ADDRESS (If rural give location) <i>6802 Navajo Drive</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<i>Jacques C Bernstein</i>		<i>10-14-1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
	<i>Married</i>		
9. AGE last birthday <i>38</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Salesman liquor</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Jerome C. Bernstein</i>		14. MOTHER'S MAIDEN NAME: <i>Susan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Hilda Bernstein - Same</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>420.1 CORONARY INFARCTION</i>		<i>12 hours</i>	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1, 1952</i> , to <i>October 19, 1955</i> , that I last saw the deceased alive on <i>Sept 10, 1955</i> , and that death occurred at <i>6:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Melvin N. Brown</i>		ADDRESS <i>31729 Rd</i> DATE SIGNED <i>10/15/55</i>	
M. D. <i>5700 Old Frederick Rd</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>10-16-55</i>	<i>Baltimore Hebrew</i>	<i>Balto Md</i>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>Barthelme</i>	24. FUNERAL DIRECTOR'S ADDRESS <i>Jack Lewis Inc 2100 Eutaw Pl</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NO. 1

1955 11 19

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09397

9412

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY BALTIMORE COUNTY MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MARYLAND COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY	
TOWN HOUSE IN THE PINES		TOWN 16 FUSTING AVE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 FUSTING AVE		STREET ADDRESS (If rural, give location) 3603 GLEN AVE.	
3. NAME OF DECEASED (Type or Print) JOSEPH (First) BERNSTEIN (Last)		4. DATE OF DEATH 10 (Month) 22 (Day) 1955 (Year)	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH UNKNOWN
9. AGE last birthday 80 yrs.		10. AGE last birthday (If under 1 year, give Months, Days, Hours, Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPTOMETRIST		10b. KIND OF BUSINESS OR INDUSTRY OPTICAL	
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME HARRY BERNSTEIN		14. MOTHER'S MAIDEN NAME GERTRUDE RICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS MRS ALBERT STARK 3603 GLEN AVE, BALTIMORE, MD.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a).... MYOCARDIAL INFARCTION			5 MINUTES
Antecedent cause(s) (b).... CORONARY ARTERIOSCLEROSIS			1 YEAR
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).... GENERALIZED ARTERIOSCLEROSIS			5 YEARS
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE			
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19 50 , to 10-22 , 19 55 , that I last saw the deceased alive on....., 19 55 , and that death occurred at..... 8 Pm., from the causes and on the date stated above.			
SIGNATURE Melton Bernstein M.D.		ADDRESS 3202 TANEY RD, BALTIMORE 15, MD	
DATE SIGNED 10-22-55			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF 10-23-54	
NAME OF CEMETERY OR CREMATORY Rosevale		LOCATION (City, town, or county) (State) Baltimore Md	
DATE REC'D BY LOCAL REG. 10-23-55		REGISTRAR'S SIGNATURE V E Harry	
F. FUNERAL DIRECTOR Jack Lewis		ADDRESS 2100 Eutan Pl	

MARGIN RESERVED FOR BINDING

VS. A15

100-100



100-100



9413

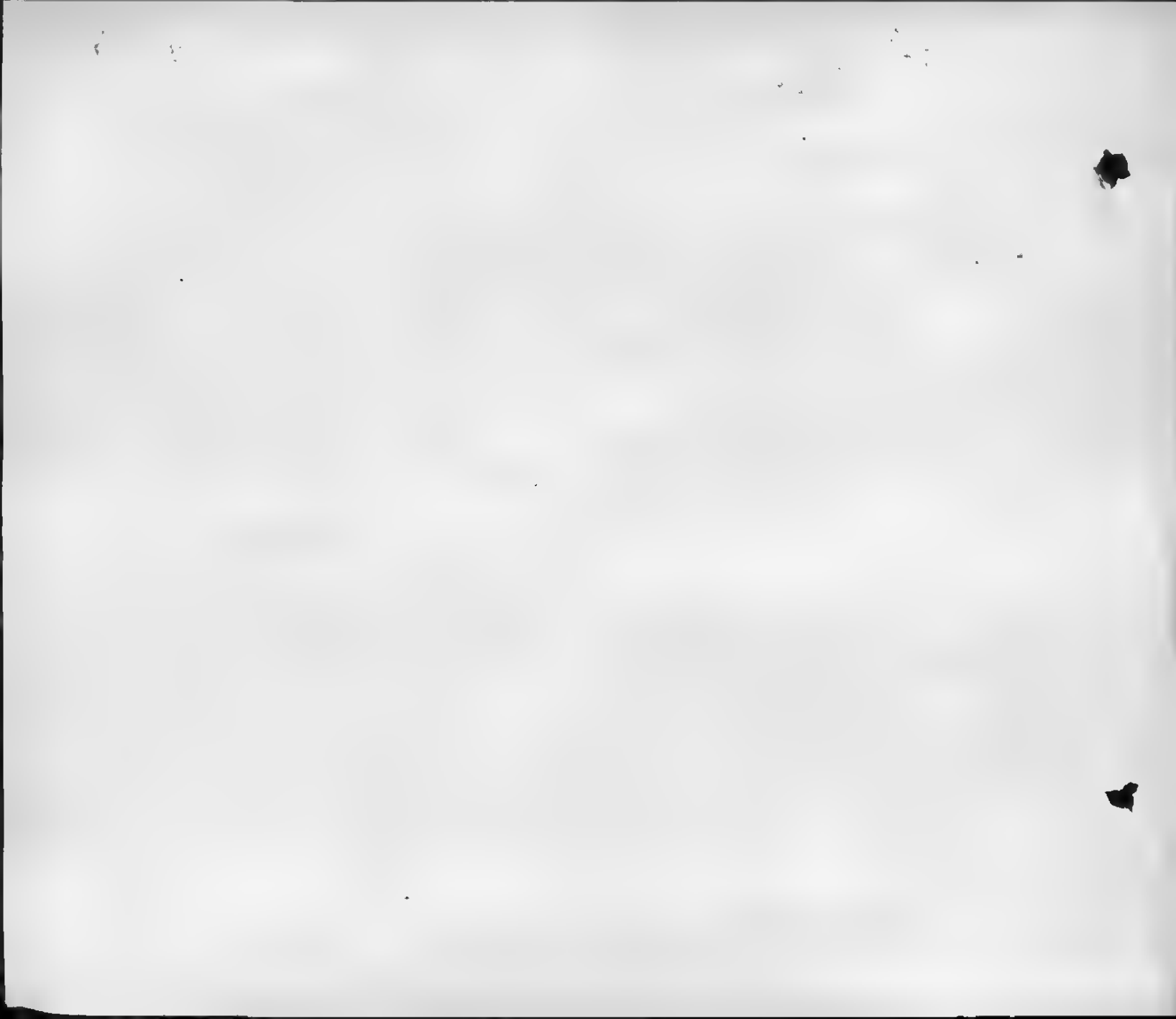
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Id.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Carney</u>				OR TOWN <u>Carney</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2615 Joppa Terr.</u>				STREET ADDRESS (If rural give location) <u>2615 Joppa Terrace</u>			
3. NAME OF DECEASED: (First) <u>LEVIN</u>		(Middle) <u>R.</u>		(Last) <u>BLOEDORN</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 30, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 5, 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>rtd</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Stock Exchange</u>		11. BIRTHPLACE (State or foreign country): <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>William Bloedorn</u>				14. MOTHER'S MAIDEN NAME: <u>Annie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war-on dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>211-20-6072</u>		17. INFORMANT & ADDRESS: <u>Mrs. Grace A. Bloedorn-2615 Joppa Terr.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>7 days</u>	
ANTECEDENT CAUSE (B) <u>Cardio-vascular disease</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>						<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1952</u> , 19, to <u>Oct 30, 1955</u> that I last saw the deceased alive on <u>Oct. 29, 1955</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas W. Todd</u>		ADDRESS <u>M. D. 2108 St Paul St.</u>		DATE SIGNED <u>10/31/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>11/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Home Cem.</u>		LOCATION (City, town, or county) (State) <u>Chicago, Ill.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/1/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>John J. Dickerson & Sons</u>		ADDRESS <u>Route 17 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9414

CERTIFICATE OF DEATH

Reg. Dist. No.

809398

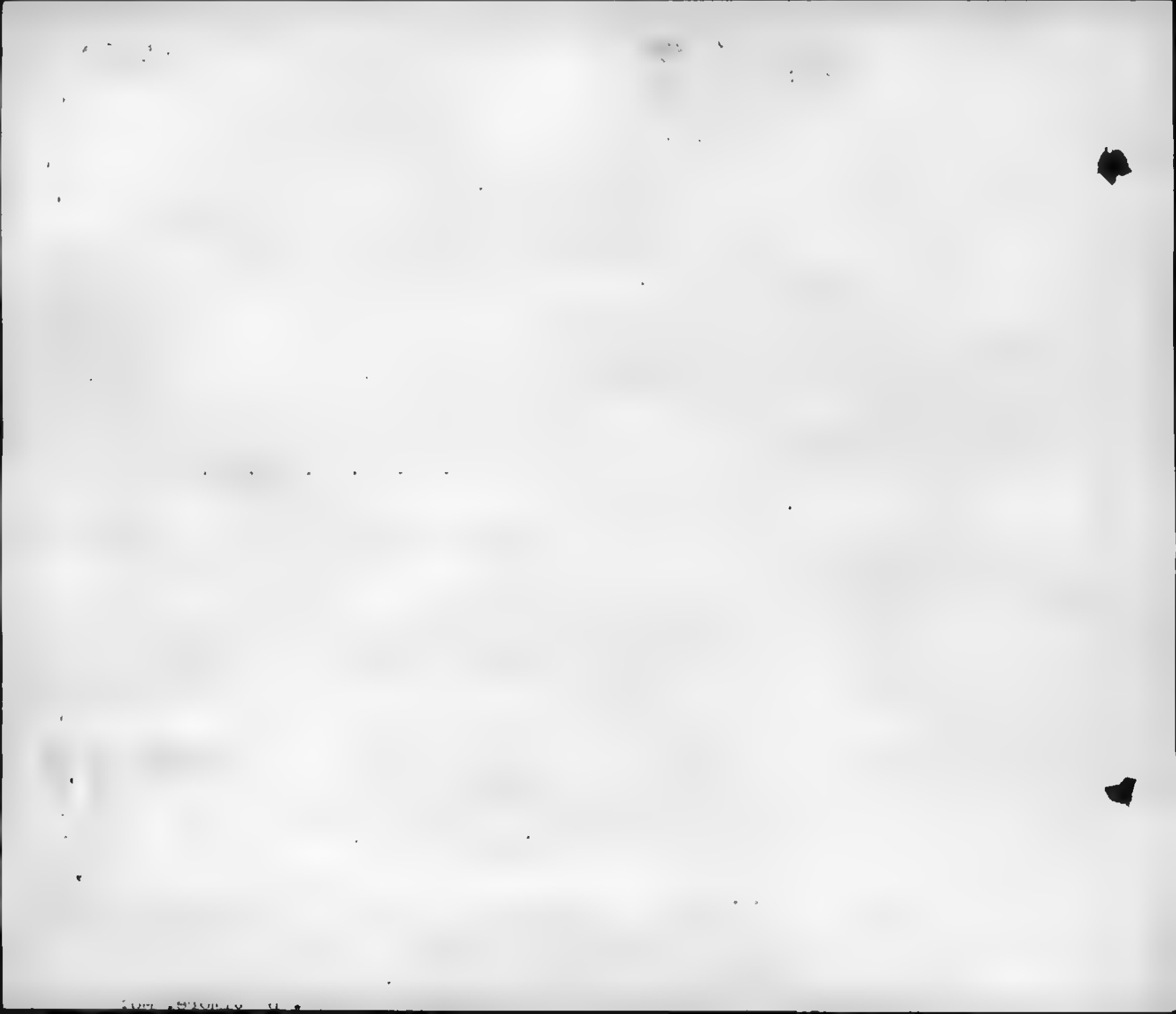
444

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>L...</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>FORT HOWARD</u>	LENGTH OF STAY (in this place) <u>2 HRS. 20 MINS.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>1319 BIRCH AVENUE</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM T. BLOUNT</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>OCTOBER 1 19 55</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, (Specify): <u>DIVORCED</u>	8. DATE OF BIRTH: <u>8/12/25</u>
9. AGE last birthday: <u>30</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>TECHNICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>ELECTRICAL</u>	
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>MACK BLOUNT</u>		14. MOTHER'S MAIDEN NAME: <u>RUTH MCCARRON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>221-72-0863</u>	
17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4.20</u> IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u> DUE TO ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>GLOMERULONEPHRITIS</u>		UNKNOWN	
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22 I hereby certify that VA attended the deceased from OCT. 1, 1955, to OCT. 1, 1955, and that death occurred at 4:35 PM, from the causes and on the date stated above.			
SIGNATURE <u>W. J. Pijak, M.D.</u>		ADDRESS <u>VAH, FORT HOWARD, MD.</u> DATE SIGNED, <u>10/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF <u>10-5-55</u>	NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>	LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
DATE FILED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Oct. 6-55 D. L. Harbor</u>	24. FUNERAL DIRECTOR ADDRESS <u>HC AND N. WHEARD FORT AT HOME 1107 Wilkens Av. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

U.S. A11-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9415

CERTIFICATE OF DEATH

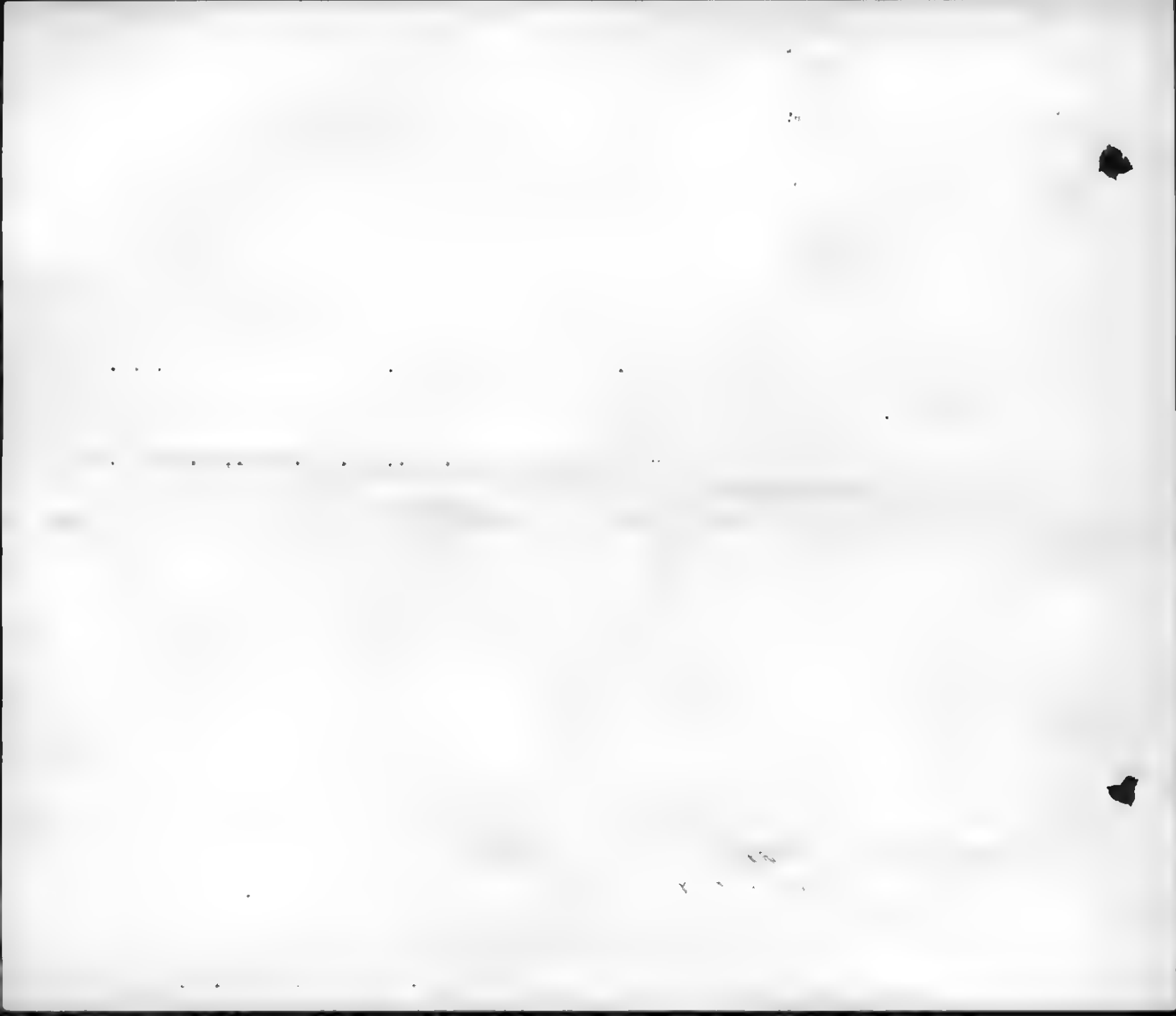
Reg. Dist. No.

09400

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD,		23 DAYS		TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 442 E. CROSS STREET			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
GEORGE (NMI) BOERNER				OF DEATH: OCTOBER 8 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	9-1-97	58 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
CARPENTER		STEEL CO.		BRUNSWICK, MARYLAND		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
WALTER E. BOERNER				REBECCA MOHN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
YES				214-03-5056		CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTIONS LEFT VENTRICLE						UNKNOWN	
DUE TO							
ANTECEDENT CAUSE (B) CORONARY ARTERIOSCLEROSIS AND THROMBOSIS						UNKNOWN	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 15, 19 55 to OCT. 8, 19 55 and that death occurred at 7:45A M. , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
WILLIAM B. VANDERGRIFF		M. D. VAH, Fort Howard, Md.		10/9/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		10/11/55		GLEN HAVEN MEMORIAL PARK		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10-10-55		✓		JAMES L. MCCULLY FUNERAL HOME		128 E. FORT AVE. Balto. MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9416

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09401
Reg. Dist.

No. 3

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Baltimore</u>		<u>3 mos. 20 days</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1117 Grove State Hospital</u>			STREET ADDRESS (If rural, give location)		
			<u>470 Maple Avenue</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First) (Middle) (Last)			(Month) (Day) (Year)		
<u>Frieda</u> <u>Rosen</u>			<u>October 13, 1955</u>		
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	
8. DATE OF BIRTH: <u>4-13-71</u>		9. AGE last birthday: <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unknown</u>		11b. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Gilman</u>			14. MOTHER'S MAIDEN NAME: <u>Rebecca Gilman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No: <u>Unknown</u>		
17. INFORMANT & ADDRESS: <u>Records, Ring Grove State Hospital</u>					

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>422.1</u> Immediate cause (a)..... <u>Acute cardiac failure</u> DUE TO					
Antecedent cause(s) (b)..... <u>Arteriosclerotic cardiovascular disease</u> DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... <u>Senility</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
				(State)	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE: <u>Dr. M. Kieffer</u>		CHIEF MEDICAL EXAMINER		DATE SIGNED: <u>10-13-55</u>	
		DEPUTY MEDICAL EXAMINER			
		M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, OR REMOVAL (Specify): <u>Removal</u>		DATE THEREOF: <u>10/14/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Westlawn, Del. Co.</u>	
LOCATION (City, town, or county) (State): <u>Washington D.C.</u>		24. FUNERAL DIRECTOR: <u>B. Dargatzis & Son</u>		ADDRESS: <u>8501-14th Ave N.W.</u>	
DATE REC'D BY LOCAL REG. <u>10/13/55</u>		REGISTRAR'S SIGNATURE: <u>T. E. Harry</u>			



9417

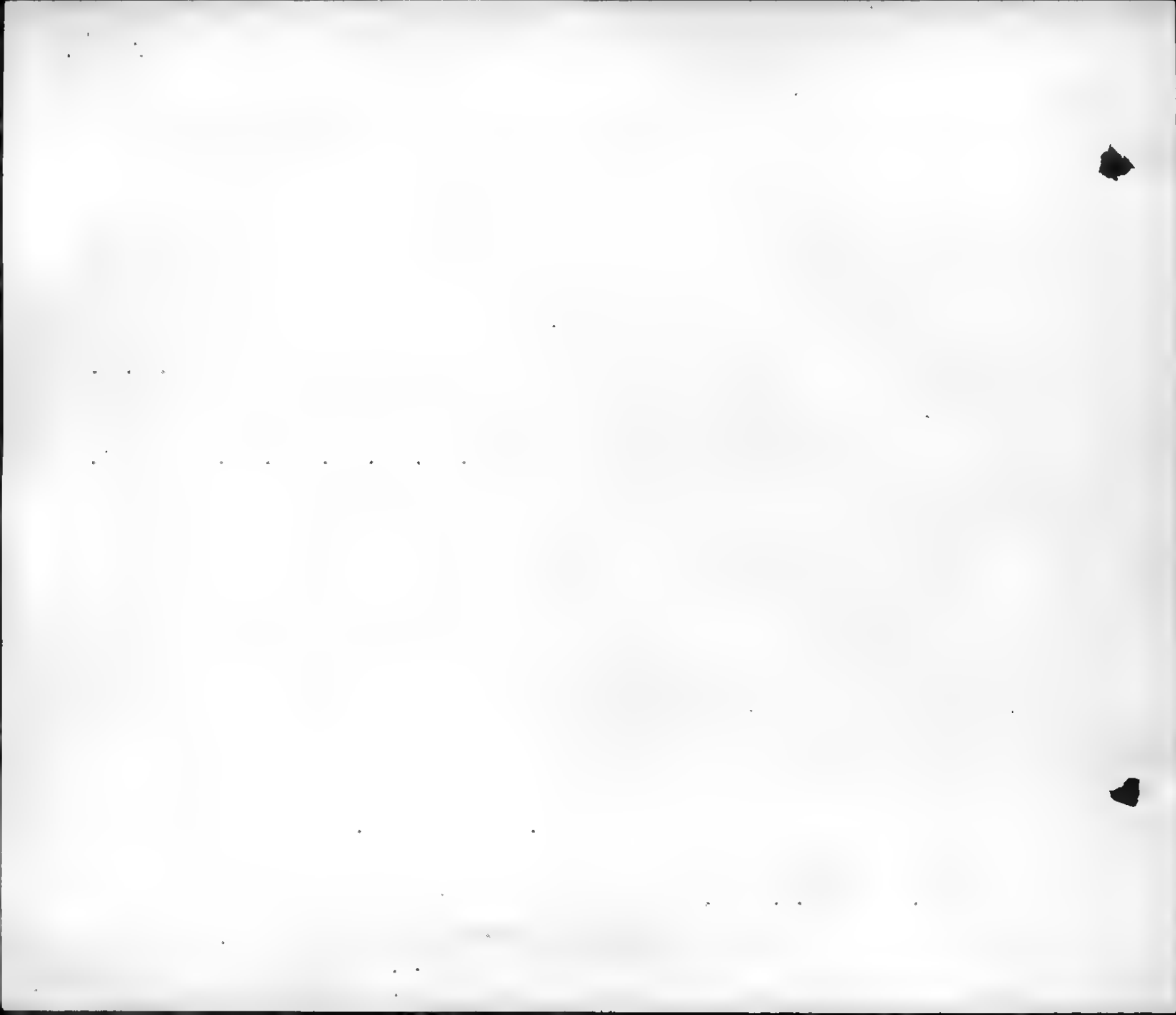
CERTIFICATE OF DEATH

Reg. Dist. No.

094024

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> TOWN <u>FORT HOWARD</u>		<u>68 DAYS</u>		TOWN <u>GLEN BURNIE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50</u> <u>VETERANS ADMINISTRATION HOSPITAL</u>				<u>1000 CRAIN HIGHWAY</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
DECEASED: (Type or Print) <u>WILLIAM</u> <u>BOSTON</u>		DATE OF DEATH: <u>OCTOBER 12</u> <u>1955</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>COLORED</u>	<u>MARRIED</u>	<u>4-12-95</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>TANNERY</u>		<u>WATERBURY, MARYLAND</u>		<u>U. S. A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>DAVID N. BOSTON</u>				<u>MARIE JACOBS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>YES</u> (If Yes, give war or dates of service, <u>WW I</u>)		<u>Unknown</u>		<u>CLIN.REC.VET.ADM.HOSP., FT.HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>012.0</u>							
IMMEDIATE CAUSE (A) <u>TUBERCULOSIS OF VERTEBRAE T-10, T-11, T-12</u>							
ANTECEDENT CAUSE (B) <u>AND L-1</u>				<u>UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>PARAPLEGIA</u>							
<u>BACTEREMIA, PROTEUS VILGARIS</u>				<u>UNKNOWN</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>8-18-55</u>		<u>Anterior-lateral decompression of cord</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
				INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>VA</u> M.							
22. I hereby certify that I attended the deceased from <u>AUG. 5</u> , 1955, to <u>OCT. 12</u> , 1955, and that death occurred at <u>3:25AM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Francis G. Dickey, M.D. Chief Medical Service</u>		<u>VAH, FORT HOWARD, MARYLAND</u>		<u>10-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>BURIAL</u>		<u>10-15-55</u>		<u>BALTIMORE, MARYLAND</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		GENERAL DIRECTOR			
<u>10-12-55</u>		<u>CE</u>		<u>ELROY D. WILSON FUNERAL HOME-1000 BRANTLEY</u>			
				<u>BALTIMORE, MARYLAND</u>			
				<u>AVE.</u>			

MARGIN RESERVED FOR BINDING



9418

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<i>Uppeco-Rural</i>	<i>30 yrs</i>	<i>Uppeco-Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		

3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
<i>ALBERT - S - BROWN</i>			<i>Oct 5 - 1955</i>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
<i>M</i>	<i>W</i>	<i>Married</i>	<i>Feb 2 - 1878</i>	<i>77 yrs</i>	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		
<i>Owner</i>			<i>Farm</i>		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
<i>Maryland</i>			<i>U.S.A</i>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<i>John Brown</i>			<i>Rebecca Myers</i>		
15. (Was deceased ever in U.S. Armed Forces? (Yes, no, or unk.) (If Yes, give year or dates of service)			16. SOCIAL SECURITY NO.		
<i>no</i>			<i>✓</i>		
17. INFORMANT & ADDRESS:					
<i>Harlem Brown - Reisterstown Md</i>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
42.1 IMMEDIATE CAUSE		
(A) <i>Coronary Thrombosis</i>		<i>1/2 hr</i>
ANTECEDENT CAUSE (B)		
(B) <i>Coronary Arterio Sclerosis</i>		<i>8 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DIO (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>May</i> , 19 <i>55</i> , to <i>Oct 5</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Oct 5</i> , 19 <i>55</i> , and that death occurred at <i>6:00</i> M, from the causes and on the date stated above.	
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SIGNATURE <i>M. B. Ellis</i>	M. O. <i>Harlem Brown</i>	DATE SIGNED <i>10-5-55</i>
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23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>Oct 8/55</i>	<i>Mr Zion</i>	<i>Balto MD</i>	<i>MD</i>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<i>10-5-55</i>	<i>Mary B. Ellis</i>	<i>Edw Chilton</i>	<i>Hanover Md</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1914

1915

1

1916

1917

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09404
9419 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>52 Catonsville 28</u>	LENGTH OF STAY (In this place) <u>Since 10/10/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Havre de Grace 12-24-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>Grovers Hill</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>DAVID</u> <u>BUNCE</u>		<u>10</u> <u>21</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>M</u>	8. DATE OF BIRTH: <u>?</u>
9. AGE last birthday <u>85</u> yrs.		10. BIRTHPLACE (State or foreign country):	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Jacob Bunce</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret McCommons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>177X</u>			
(A) <u>Carcinoma of Prostate</u>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>			
19A. DATE OF OPERATION: <u>9.3.55</u>		19B. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Prostate (University Hospital Balto)</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 10</u> , 19 <u>55</u> , to <u>10 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10 21</u> , 19 <u>55</u> , and that death occurred at <u>6 p</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Rena Becker</u>		DATE SIGNED <u>10/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-24-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Darlington, Harford County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/27/55</u>		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Pennington & Son, Havre de Grace, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09405

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH. COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Baltimore</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Litchfield Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>Maryland</u> <u>Baltimore</u> STATE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>Baltimore</u> STREET ADDRESS <u>10 Litchfield Rd.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Sven Erick Carlson</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct</u> <u>25</u> , 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Jan 11, 1931</u>
9. AGE last birthday: <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>contractor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Hauling</u>	
11. BIRTHPLACE (State or foreign country): <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>✓</u>	
13. FATHER'S NAME: <u>Carlson</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>215-32-1325</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Lundin 910 Litchfield Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral accident</u> ANTECEDENT CAUSE (S) <u>due to</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive Cardio-vascular Disease</u> (C) <u>Influenza</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 15 min.</u> <u>about 3 yrs.</u> <u>4 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>-----</u>		19B. MAJOR FINDINGS OF OPERATION: <u>-----</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-----</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 17, 1955</u> , to <u>Oct. 25, 1955</u> , that I last saw the deceased alive on <u>Oct. 24, 1955</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. SIGNATURE <u>John G. Maw</u> ADDRESS <u>M.O. 516 Cathedral St.</u> DATE SIGNED <u>Oct. 26, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 28, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cent</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>John G. Maw</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>7000 E. Balto. St.</u>	



9375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>DUNDALK - Md.</u>				<u>DUNDALK - Md.</u> 53			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		88 Baltimore Ave.		STREET ADDRESS (If rural give location)			
				<u>88 Baltimore Ave.</u> 1			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>WALTER MILLS Carmine MD</u>				<u>10 13 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 60 Min.
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>Sept. 26, 1881</u>	<u>74</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>Physician</u>			<u>Self Emp</u>		<u>Md.</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Carmine</u>				<u>Mary F. Stevens</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>						<u>Dundalk, Md.</u> <u>Mrs. Anita S. Carmine - 88 Balto. Ave.</u>	
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE						<u>10 hrs.</u>	
(A) DUE TO <u>Coronary Occlusion</u>							
ANTECEDENT CAUSE (B):						<u>2.3 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO <u>Myocarditis, Chronic</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/12/55</u> to <u>10/13/55</u> , that I last saw the deceased alive on <u>10/12/55</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		ADDRESS			
<u>W. J. G. Davis MD</u>		<u>10/13/55</u>		<u>M. D. Dundalk - Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/15/55</u>		<u>Denton Cem.</u>		<u>Denton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>11/4/55</u>				<u>Wm. J. Pickner & Sons</u>		<u>Balto 17 A</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G188 11-10-55 et

9421

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09407

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Landover</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>8620 Landover Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Martha</u> <u>Carr</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>October 31, 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>October 30, 1910</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laundry Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Ft Meade Camp</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John L. Wilson</u>				14. MOTHER'S MAIDEN NAME: <u>Haddie V. Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u>						<u>10 minutes</u>	
ANTECEDENT CAUSE (B) <u>Pulmonary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Dehydration</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-22-</u> , 19 <u>55</u> to <u>10-31-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-31-</u> , 19 <u>55</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sella Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u>		DATE SIGNED <u>10-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 3 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov 8-9-55</u>		REGISTRAR'S SIGNATURE <u>J. J. Sever</u>		24. FUNERAL DIRECTOR <u>F. Sacher</u>		ADDRESS <u>Hyattsville, Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9376

09408

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 41...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>3</u> TOWN <u>Dundalk</u>				OR TOWN <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7501 German Hill Road</u>				STREET ADDRESS (If rural, give location) <u>7501 German Hill Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(Type or Print) <u>Henry</u>		(First) <u>E</u>		(Last) <u>CARROLL</u>		(Month) (Day) (Year) <u>Oct. 17 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>married</u>	<u>May 8, 1887</u>	<u>68</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Nurseryman</u>		<u>Colgate Nursery</u>		<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Edward Carroll</u>				<u>Laura Napier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>no</u>						<u>Anna Smith, dght, 514 Quail St., Zone 24</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>430.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>INJURY</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Edward Carroll</u>		M. D.		DATE SIGNED <u>10/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>10/20/55</u>		REGISTRAR'S SIGNATURE <u>A. K. Hildach</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
		24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>2601-3-5 E. Madison St.</u>	



9422

CERTIFICATE OF DEATH

09409

Reg. Dist. No. 40

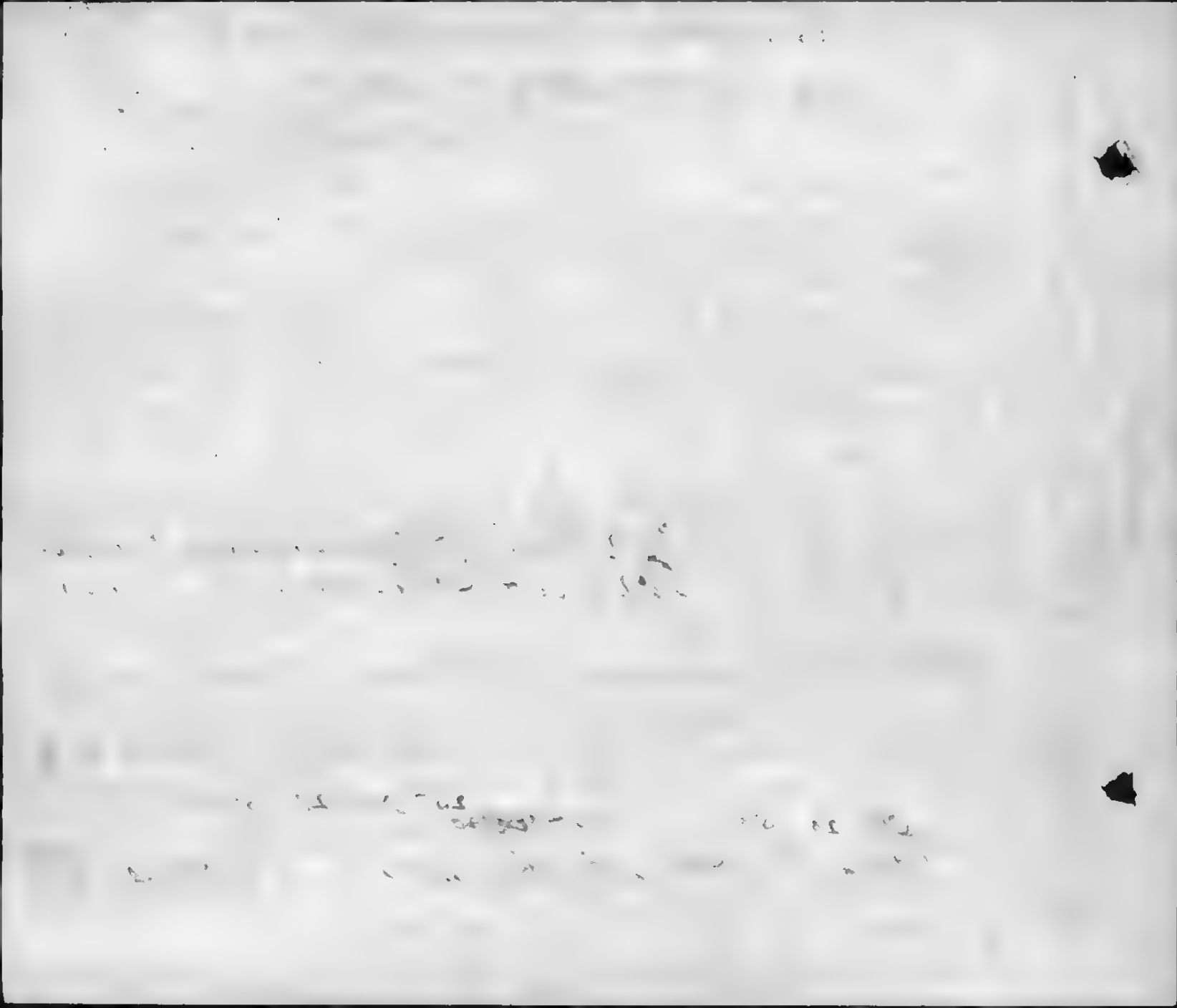
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Long Green</u>		<u>45 yrs</u>		TOWN <u>Long Green Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Lurcia Grace Carter</u>				<u>Oct 21 - 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>married</u>	<u>Nov 28-1875</u>	<u>79</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Housewife</u>				<u>✓</u>		<u>Md</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U.S.A.</u>				<u>S. S. Smith</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Catherine A. Hoyt</u>				<u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
<u>✓</u>				<u>D. W. Carter Long Green Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Arterio-sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>3 weeks</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)			
				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)				21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 20</u> to <u>Oct 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>55</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Halter M. Hammett M.D.</u>				<u>Baltimore Md</u>			
DATE SIGNED				DATE SIGNED			
<u>Oct 20 - 55</u>				<u>Oct 20 - 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Bural</u>		<u>Oct 24-55</u>		<u>Fork M. Ch. Cem</u>		<u>Fork Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct 25-55</u>		<u>G. E. Arthur</u>		<u>G. E. Arthur</u>		<u>Fork Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9423

09410

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Reisterstown		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Glyndon			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main Street				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) Andre		(Middle) Cere		(Last) Cere		4. DATE OF DEATH (Month) Oct. 2 (Day) 19 (Year) 55	
5. SEX: M.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: April 20, 1901		9. AGE last birthday: 54 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farmer		10b. KIND OF BUSINESS OR INDUSTRY: Employee		11. BIRTHPLACE (State or foreign country): Bordeaux France		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME: Unknown Cere				14. MOTHER'S MAIDEN NAME: Helena Cere			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 215-32-2523		17. INFORMANT & ADDRESS: Mrs Arther Foster, Glyndon, Md.			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 221X Immediate cause (a) ... Cerebral Hemorrhage DUE TO Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						20 min.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. alcohol Intoxication						1 hr	
19a. DATE OF OPERATION: none		19b. MAJOR FINDING OF OPERATION: none				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE A. D. Peoples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Oct 3 '55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: Oct. 5, 1955		NAME OF CEMETERY OR CREMATORY: All Saints Cemetery		LOCATION (City, town, or county) (State): Reisterstown, Md.	
DATE REC'D BY LOCAL REG. 10-5-55		REGISTRAR'S SIGNATURE: Mary B. Eline		24. FUNERAL DIRECTOR: J.F. Eline & Son's		ADDRESS: Reisterstown, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

9424

2411 N. Charles Street, Baltimore

09411

CERTIFICATE OF DEATH

Reg. Dist. No. *1*

1. PLACE OF DEATH- COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middle River</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural Middle River</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>7 Compass Rd.</i>		STREET ADDRESS (If rural, give location) <i>7 Compass Rd.</i>	
3. NAME OF DECEASED (Type or Print) <i>Artenia S. Cherry</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Oct. 22 1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 13, 1884</i>
9. AGE last birthday <i>71</i>		10. AGE last birthday If under 1 year: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Stonebraker</i>		14. MOTHER'S MAIDEN NAME <i>Alice Baughman</i>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT AND ADDRESS <i>Charles H. Cherry - 7 Compass Rd.</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>155 X Immediate cause</i> (a) <i>Carcinoma of Gallbladder</i> Antecedent cause(s) (b) <i>3 mo.</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>W.B.</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept. 1953</i> to <i>Oct. 1955</i> , that I last saw the deceased alive on <i>10-22-55</i> and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Marvin Romber, M.D.</i> ADDRESS <i>808 F. Village Lane</i> DATE SIGNED <i>10-24-55</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>		DATE THEREOF <i>Oct. 24, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Martinsburg, Pa.</i>		LOCATION (City, town, or county) (State) <i>Martinsburg, Pa.</i>	
DATE REC'D BY LOCAL REG. <i>10/24/55</i>		REGISTRAR'S SIGNATURE <i>Abie Medzich</i>	
24. FUNERAL DIRECTOR <i>Funeral Home - 7401 Main Rd.</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2. 4. 1975



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

<div style="text-align: center;"> <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center; margin: 0 auto;">2</div> <div style="margin-left: 10px;"> MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09412 9425 CERTIFICATE OF DEATH Reg. Dist. No. </div> </div>			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL or give nearest town) TOWN Catonsville LENGTH OF STAY (in this place) 28 days HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Relay 51 STREET ADDRESS (If rural give location) 4923 Cedar Avenue 1	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) (Middle) (Last) Rose Anna Clark		October 17, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Female	White	Single	9-16-1878
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	
77 yrs.		None	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
North Carolina		USA	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Aaron Clark		Mary Francois	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Records Spring Grove State Hospital		18A. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 492 X IMMEDIATE CAUSE (A) Pneumonia ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) 18B. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-19- , 19 55 to 10-17- , 19 55 that I last saw the deceased alive on 10-17- , 1955, and that death occurred at 10:40AM from the causes and on the date stated above.			
SIGNATURE Shula Hachler		DATE SIGNED 10-17-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR ADDRESS	
Burial		Spring Grove State Hospital	
DATE REC'D BY LOCAL REGISTRAR 10-19-55		REGISTRAR'S SIGNATURE Harvey H. Witzke	
NAME OF CEMETERY OR CREMATORY Laurel Park		LOCATION (City, town, or county) Baltimore, Md	

11111

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09413

9426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shady Nook Nursing Home 1002 N. Rolling Rd.</u>		STATE <u>Md.</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>430 Drury Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY E. CLARKE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 26, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Sept. 13, 1872</u>
9. AGE last birthday: <u>83</u> yrs.		10. AGE last birthday: <u>83</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Rhineschild</u>		14. MOTHER'S MAIDEN NAME: <u>Linley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Pittsburgh 34, Penna. Mrs. M. R. Clifton-109 Parkside Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>444X</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Cerebral Hemorrhage</u>		<u>14 de.</u>	
(B) <u>Hypertensive Cardio-Vascular Disease</u>		<u>103y(?)</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-10</u> , 19 <u>50</u> , to <u>10-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-26</u> , 19 <u>55</u> , and that death occurred at <u>7:15 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>William K. Gallagher</u>		ADDRESS <u>M. D. Catonsville-28</u>	
DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Entombment</u>		<u>10/29/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Lorraine Maus.</u>		<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>10-29-55</u>		<u>Wm. J. Lickner</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Wm. J. Lickner</u>		<u>404-17</u>	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10484

9428

CERTIFICATE OF DEATH

Reg. Dist. No...

30

Items 2,6 Film 191 1-19-56 et

1. PLACE OF DEATH:

County Baltimore
 City or town Bethesda - Potomacville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs
 Hospital, institution, or street address where death occurred:
Hood's Convalescent Home
 How long in hospital or institution? 90

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Unknown County Unknown
 City or town Unknown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Unknown
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clara Kelley

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6. (a) Single, married, widowed, or divorced Unknown

6. (b) Name of husband or wife Unknown

7. Birth date of deceased (mo., day, yr.)

8. AGE: 84 Years Months Days If less than one day
 hrs. min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Cremation Date thereof Nov. 8, 1955
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Univ. of Md. Medical School
 Location 29 South Greene St.; Balto. 1, Md.

18. Funeral director

Address

19. Nov. 10, 1955 19 Nov. 10, 1955
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 N 55 350 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 47 to Oct 21 19 55
 and that I last saw him alive on Oct 20 19 55

Immediate cause of death Cancer of Breast 8 yrs

Due to

Due to

Other conditions Generalized Metastasis

170 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Esfowes M. D. or otherAddress Latonaville Date signed 10-21



09415

MARYLAND STATE DEPARTMENT OF HEALTH

9429

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 35

Item 7, File 187 10-12-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pa.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>York Rd.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u> TOWN <u>Reading</u> STREET ADDRESS <u>816 Fairbairn Blvd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Cheta Arthur Corington</u>		4. DATE OF DEATH <u>Oct. 3</u> 19 <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 12, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF, WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Corington</u>		14. MOTHER'S MAIDEN NAME <u>Ananda Lenta</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give nat. or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>318-14-6244</u>	
17. INFORMANT AND ADDRESS <u>Carroll E. F. Home, Gettysburg, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause: <u>812X</u> (a) <u>Crushed skull, compound fracture of both lower extremities</u>			
Antecedent cause(s): (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway 111</u> (CITY OR TOWN) <u>Reading</u> (COUNTY) <u>Balt.</u> (STATE) <u>Ind</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 3, 1955 6:15 PM</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Struck by automobile</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>A. M. Francis</u> (Degree or title) <u>M.D.</u>		ADDRESS <u>Baltimore Ind.</u> DATE SIGNED <u>10/2/55</u>	
23. BURIAL, CREMATION REMOVAL Specify <u>Burial</u>		DATE THEREOF <u>10-12-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Alton Nat. Cemetery</u>		LOCATION (City, town, or county) <u>Alton, Illinois</u> (State) <u>Ill.</u>	
DATE REC'D BY LOCAL REG. <u>10/12/55</u>		24. FUNERAL DIRECTOR <u>Brooks Funeral Service, Sparks, Md.</u> ADDRESS <u>Sparks, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COR. Corbett

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 10-31-55

09416

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>A. A.</u>			
CITY (If outside corporate limits, write RURAL) <u>Colonsville 28</u> LENGTH OF STAY (in this place) <u>one Feb 30, 1954</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR <u>Severna Park</u> (282)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS <u>Address Home for Aged</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>CARRIE</u> (Middle) <u>MARIE</u> (Last) <u>DALEY</u>				DATE (Month) <u>10</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>August 16, 1873</u>	
9. AGE last birthday: <u>82</u> yrs		10. UNDER 1 YEAR: Months <u> </u> Days <u> </u>		11. UNDER 24 HRS: Hours <u> </u> Min. <u> </u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife at home</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>			
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Adam Treulich</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Gable</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u> </u> (If Yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO.: <u> </u>			
17. INFORMANT & ADDRESS: <u>Mrs. T. Morris Jones, P.O. Box 299, Severna Park</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiac Disease</u> DUE TO							
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u> DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rt Hemiplegia</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8. 24. , 1955</u> , to <u>10. 16 , 1955</u> , that I last saw the deceased alive on <u>10. 16 , 1955</u> , and that death occurred at <u>11 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u>		M.D. <u>Spring Grove Hosp.</u>		DATE SIGNED <u>10/16/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/55</u>		REGISTRAR'S SIGNATURE <u>John H. ...</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	



09417

9431

CERTIFICATE OF DEATH

Reg. Dist. No. 44

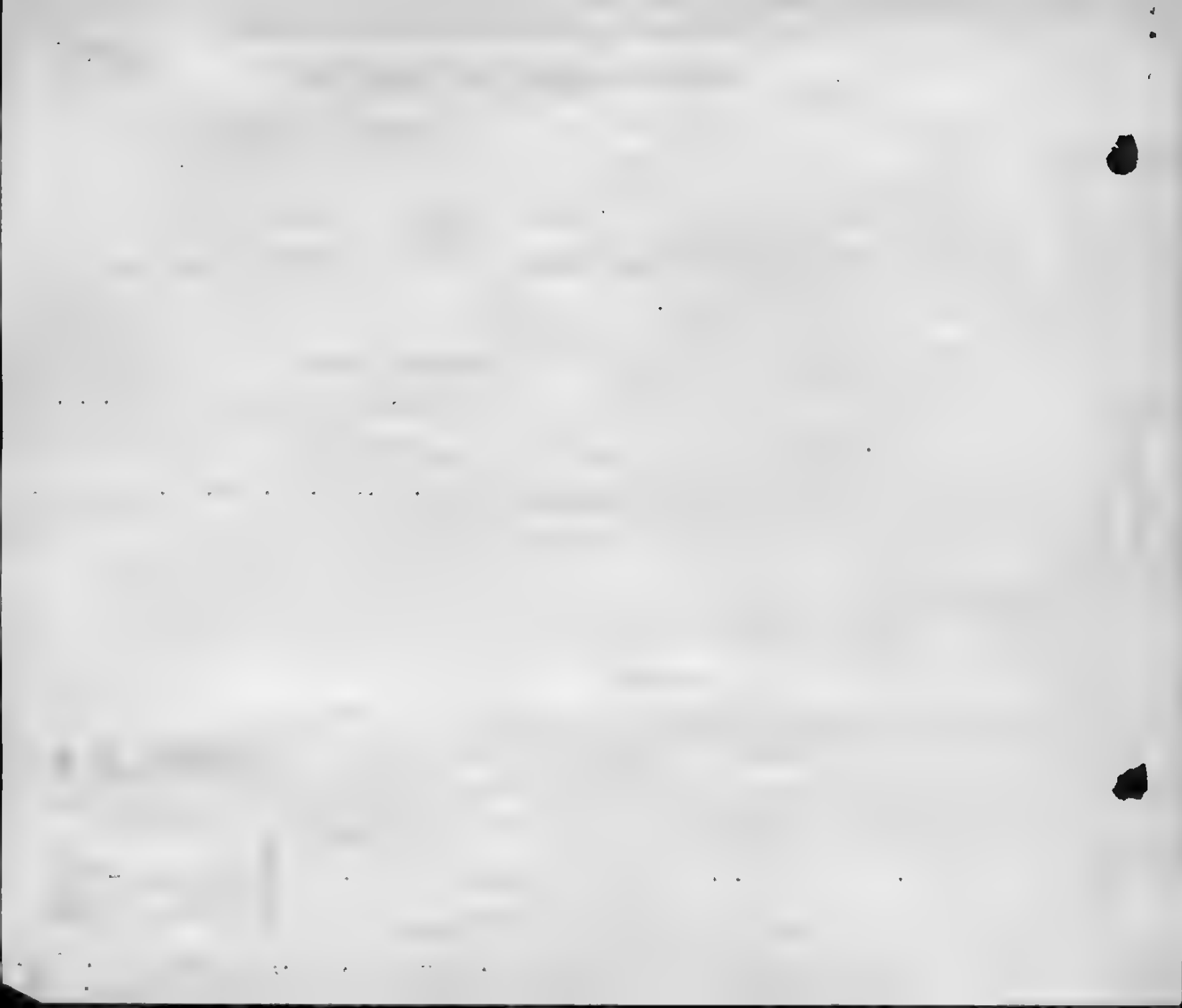
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>93 Days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2537 Greenmount Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>REUBEN D. DAVIS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 26 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/3/86</u>		9. AGE last birthday <u>69</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dunbar T. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Forney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give year or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
321X IMMEDIATE CAUSE (A) <u>LEFT CEREBRAL HEMORRHAGE</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> <u>attended the deceased from July 25, 19 55, to October 26 19 55, that he was deceased</u> <u>and that death occurred at 9:30 P.M. from the causes and on the date stated above.</u>							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>			
DATE SIGNED <u>10-27-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>OCT 31 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Oct. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Garber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09418

9432

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
TOWN <u>PARKVILLE</u> LENGTH OF STAY (In this place) <u>32 years</u>		TOWN <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2915 Roborn Ave</u>		STREET ADDRESS (If rural, give location) <u>2915 Roborn Ave</u>	
3. NAME OF DECEASED (First) <u>CORA</u> (Middle) <u>M</u> (Last) <u>DEAN</u>		4. DATE OF DEATH (Month) <u>OCT</u> (Day) <u>6</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. PREVIOUS MARRIAGE WIDOWED, PREVIOUS (Specify)	8. DATE OF BIRTH <u>Nov. 13 1874</u> 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John PRITCHETT</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET Motherset</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Lloyd B Dean</u>		2915 Roborn Ave	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerotic cardiovascular disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 wks

10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 9, 1940 to Oct 6, 1955, that I last saw the deceasedalive on Oct 6, 1955, and that death occurred at 4:15 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION

REMOVABLE (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

* Dr. E. J. Alessi
6217 Harford Rd

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

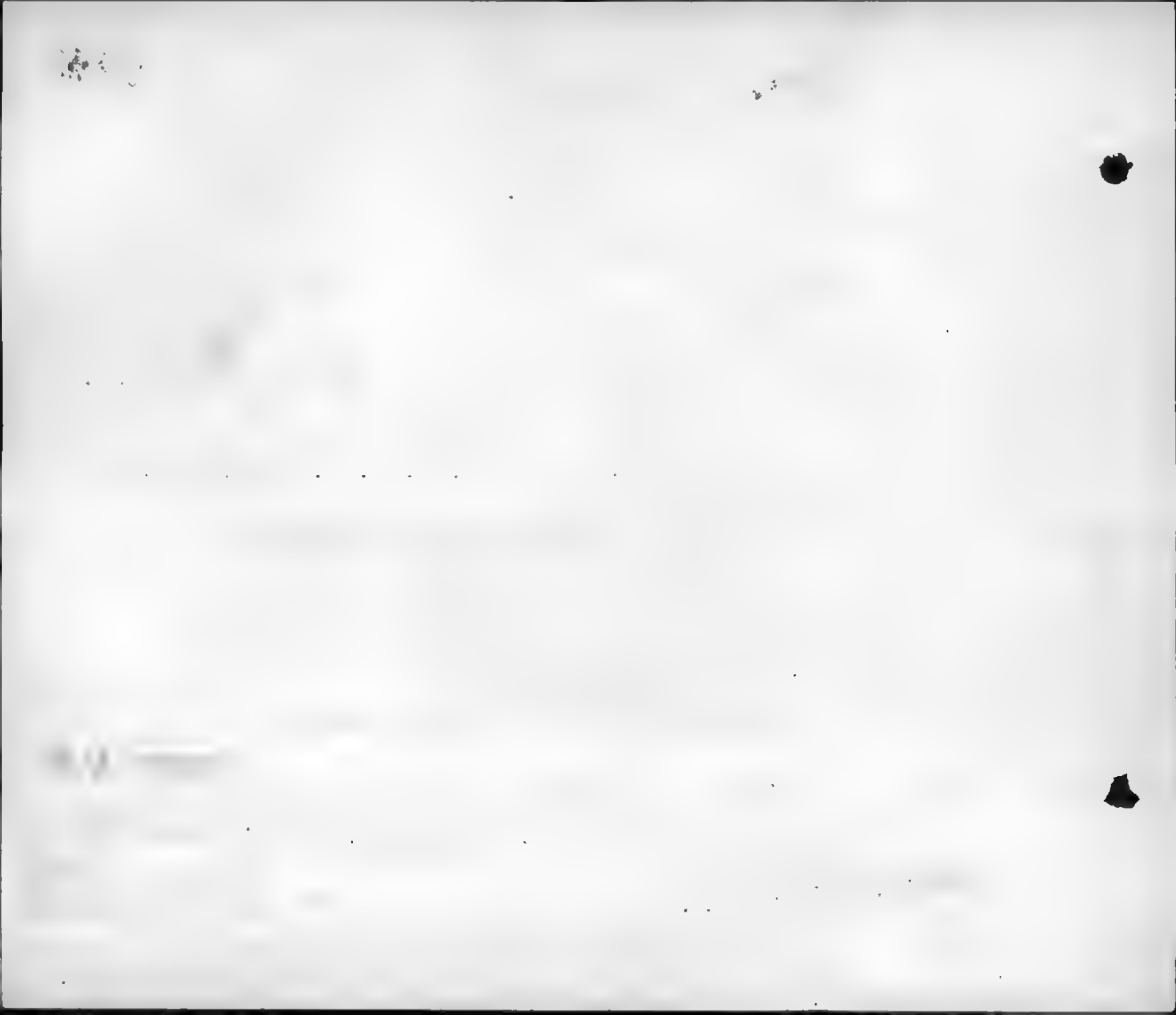
9433

CERTIFICATE OF DEATH

Reg. Dist. No.

09419

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	STATE MARYLAND COUNTY DORCHESTER	CITY (If outside corporate limits, write RURAL and give nearest town) EAST NEW MARKET
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) DUDLEY (Middle) R. (Last) DEMBY		4. DATE (Month) (Day) (Year) OF DEATH OCTOBER 2 1955	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 10-18-26
9. AGE last birthday IF UNDER 1 YEAR: 28 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCKMAN	
11. BIRTHPLACE (State or foreign country): EAST NEW MARKET, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JAMES DEMBY		14. MOTHER'S MAIDEN NAME: FRANCES FARROW	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES KOREAN		16. SOCIAL SECURITY NO.: 218-16-6754	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP. FT. HOWARD, MARYLAND		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) GLIOMA, RIGHT LATERAL VENTRICLE		UNKNOWN	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 10-2-55		19B. MAJOR FINDINGS OF OPERATION: CRANIOTOMY - BILATERAL TREPHINE - TRACHEOSTOMY	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from OCT. 1, 1955 to OCT. 2, 1955 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 10-3-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF OCT. 5, 1955	
NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEMETERY		LOCATION (City, town, or county) EAST NEW MARKET, MARYLAND	
DATE REC'D BY REGISTRAR 10/5/55		24. FUNERAL DIRECTOR ADDRESS J. J. FRAMPTON & SON, FEDERALSBURG, MD. MAIN STREET	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09420

9434

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Ruxton</u>				STREET ADDRESS (If rural give location) <u>5015 Roland Ave.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7912 Ruxway Rd. Sorenson Nursing Home</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 9, 1955</u>			
(Type or Print) <u>SALLIE FOSTER OWENS DENNIS</u>							
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Oct. 5, 1874</u>	9. AGE last birthday <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>	11. IF UNDER 24 HRS. Hours <u>3</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Penna.</u>	
13. FATHER'S NAME: <u>Harry Paul Owens</u>				14. MOTHER'S MAIDEN NAME: <u>Jane Foster Owen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Miss Estelle Dennis - 100 E. Monument St.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE						<u>2 months</u>	
(A) DUE TO <u>anemia</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>5 years</u>	
(B) DUE TO <u>Chronic Glomerular Nephritis.</u>							
(C) <u>myocarditis chronic.</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>anastomosis.</u>						<u>1 year.</u>	
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>none.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 2, 1955</u> , to <u>Oct. 8, 1955</u> , that I last saw the deceased alive on <u>Oct. 8, 1955</u> , and that death occurred at <u>8.30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G. M. Sorenson</u>		ADDRESS <u>M.D. 516 Cathedral St</u>		DATE SIGNED <u>10-10-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-5</u>		REGISTRAR'S SIGNATURE <u>1-</u>		24. FUNERAL DIRECTOR <u>Chas. J. Lickner & Sons - Balto.</u>		ADDRESS <u>17 A</u>	



9435

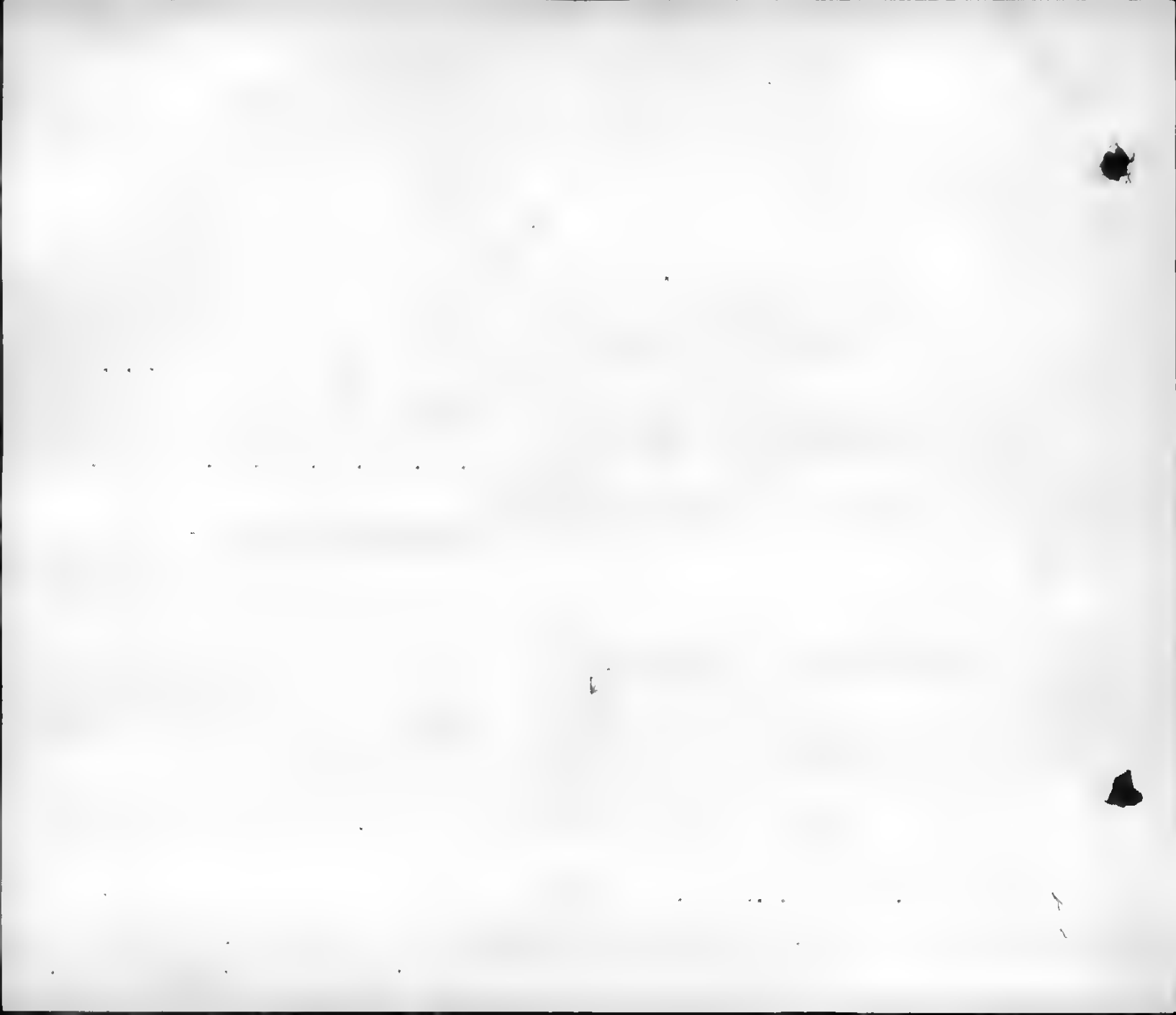
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>FORT HOWARD</u>		<u>44 DAYS</u>		OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>1206 WEST FRANKLIN STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>EDWARD C. DOCKINS</u>				OF DEATH: <u>OCTOBER 12, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLORED</u>	<u>MARRIED</u>	<u>7-11-90</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>POST OFFICE</u>		<u>BALTIMORE, MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>UNKNOWN</u>				<u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:	
<u>YES</u> <u>WW-1</u>				<u>UNKNOWN</u>		<u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>443X</u>							
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROSIS, GENERALIZED WITH HEMI-PARESIS</u>							
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							<u>2 MONTHS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							<u>UNKNOWN</u>
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
<u>VA</u>							
22. I hereby certify that I attended the deceased from <u>August 29, 1955</u> , to <u>Oct. 12, 1955</u> , and that I last saw the deceased <u>alive</u> and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				ADDRESS		DATE SIGNED	
<u>FRANCIS G. DICKEY, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND 10-13-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>10-17-1955</u>		<u>BALTIMORE NATIONAL</u>		<u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10/14/55</u>		<u>Chas. G. Cooper</u>		<u>CHARLES G. COOPER, 512 N. CARROLTON AVE.</u>		<u>BALTIMORE, MARYLAND</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9389

09422

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4K

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
51 TOWN <u>Artistown</u>	<u>3 wks</u>	TOWN <u>Artistown</u>	<u>Stardens</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4813 Fernley Square</u>		STREET ADDRESS (If rural, give location) <u>4813 Fernley Square</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>John Joseph Drake</u>		<u>Oct 19 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED:	8. DATE OF BIRTH:
<u>M</u>	<u>W</u>	<u>Widowed</u>	<u>Oct 12 1884</u>
9. AGE last birthday:		10. AGE last birthday:	
<u>71</u> yrs.		<u>71</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	
<u>Retired</u>		<u>Batchman</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Ireland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Drake</u>		<u>Mary unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS:			
<u>John Drake</u>		<u>4813 Fernley Square</u>	

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause		(a) <u>Acute Cardiac failure</u>	
DUE TO			
Antecedent cause(s)		(b) <u>Cardiovascular disease</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO	
(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
<u>Dr. W. Kieffer</u>		<u>Oct 19 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
<u>Burial</u>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Oct 19 55</u>		<u>Amos Hubbard</u>	
		ADDRESS <u>4107</u>	



9436

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chase</u>		LENGTH OF STAY (in this place) <u>18 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CHASE MD</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EBENEZER R.R.</u>				STREET ADDRESS (If rural give location) <u>EBENEZER RD</u>			
3. NAME OF DECEASED: (Type or Print) <u>FRANCIS DRAKE DUNLAP</u>				4. DATE OF DEATH: <u>10</u> (Month) <u>28</u> (Day) <u>1955</u> (Year)			
6. SEX: <u>MALE</u>	5. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>11/16/1875</u>	9. AGE last birthday: <u>79</u> yrs.		10. IF UNOER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>MECH. RETIRED PENN. R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>DELAWARE CITY DEL</u>	
13. FATHER'S NAME: <u>FRANCIS B.</u>				14. MOTHER'S MAIDEN NAME: <u>SARAH J. GARDNER</u>			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>AMELIA Dunlap CHASE MD</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4-1-1 Immediate cause (a) <u>Coronary Occlusion</u> Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular disease</u> DUE TO (c)		<u>10/27/55</u> <u>2 yrs</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1955, to Oct 28, 1955, that I last saw the deceased alive on Oct 28, 1955, and that death occurred at 7 AM, from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>		<u>10/31/55</u>	<u>OAK LAWN</u>	<u>BALTIMORE MD</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Oct 29, 1955</u>	<u>R.W.</u>	<u>Clarence F. Hoffmann 3218 Hudson</u>		

MARGIN RESERVED FOR BINDING

VS. A11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Dist. No. 23

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<p>443 X</p> <p>Immediate cause</p> <p>(a).....</p>	Cardiac Decompensation	2 yrs.
<p>Antecedent cause(s)</p> <p>Disease or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u></p> <p>(b).....</p> <p>(c)</p>	Hypertensive C-V. Disease.	5 yrs

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <i>none</i>	19b. MAJOR FINDINGS OF OPERATION <i>none</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE	(Specify) <i>none</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <i>none</i>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	<i>none</i>	m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>none</i>	

22. I hereby certify that I attended the deceased from 10-28, 1950, to 10-22, 1955, that I last saw the deceased alive on 10-21, 1953, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

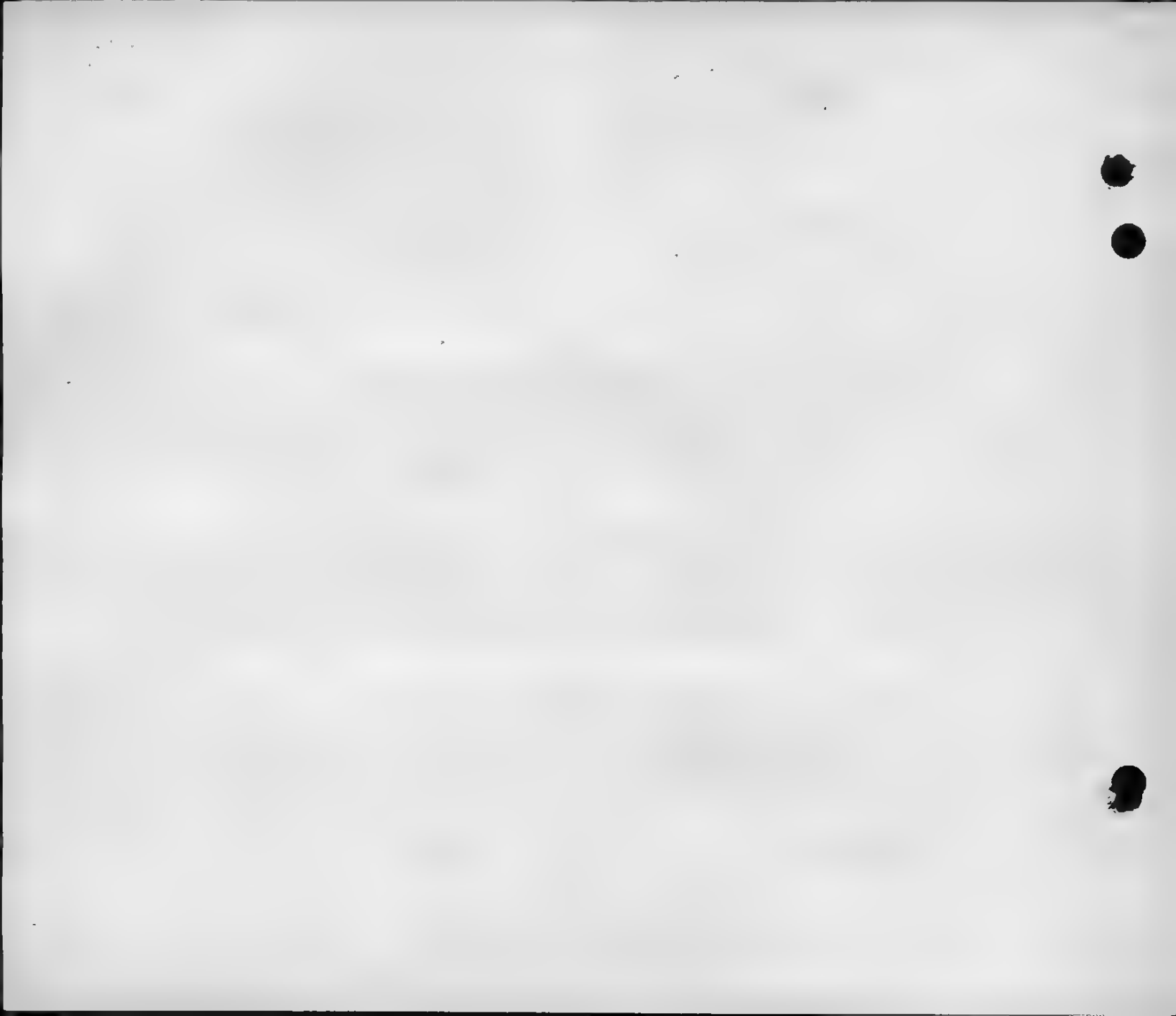
SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
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23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial		10-25-55	St. Lukes Cem.	Reisterstown,	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	ADDRESS	
10/25/55	C. G. [Signature]		M. W. [Signature]	Biddle [Signature]	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09425

9438

CERTIFICATE OF DEATH

Reg. Dist. No. 4

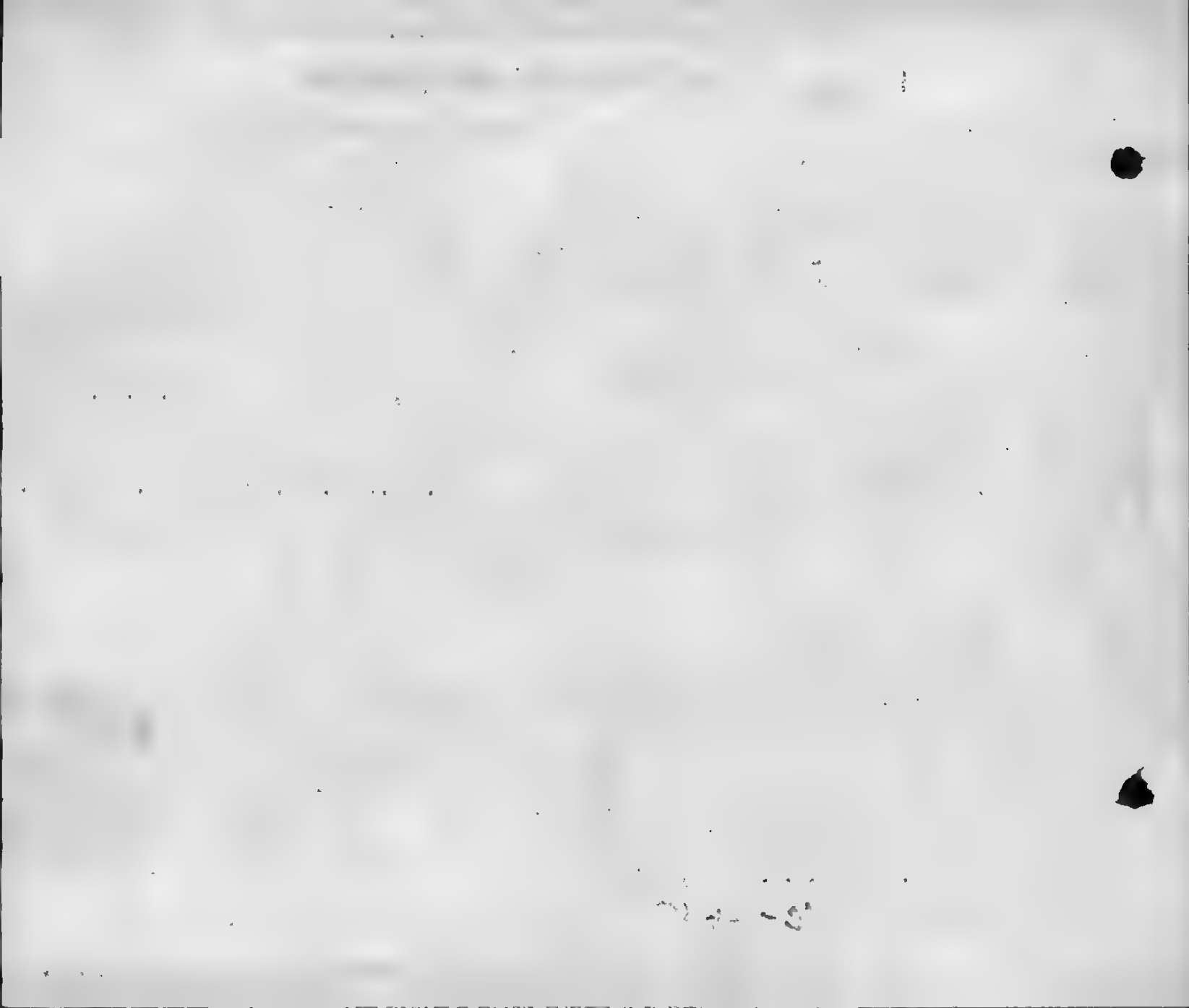
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>15 Days</u>		TOWN <u>Annapolis</u>		<u>02-10-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>61 Clay Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ENOCH ERIC (ERRIC) EBEN</u>				<u>October 20 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>July 1, 1896</u>	<u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cook</u>		<u>Hospital</u>		<u>Gaysville, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Eben</u>				<u>Elizabeth MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WW I</u>		<u>Unknown</u>		<u>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
<u>1.5 X IMMEDIATE CAUSE (A) <u>ADENOCARCINOMA OF COLON</u></u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>September 1, 1955</u>		<u>Laparotomy and ileo transverse colostomy</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 5, 1955</u>, to <u>October 20, 1955</u>, and that death occurred at <u>9:15 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
DATE THEREOF <u>10-22-55</u>				DATE SIGNED <u>10-21-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>Annapolis National</u>		<u>Annapolis, Maryland</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>DATE 10-22-55</u>		<u>William Reece</u>		<u>William Reece Funeral Home, Annapolis, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09426

1 9439

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL OR and give nearest town) Baltimore		30 1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 73 Wayne Nursing Home 98 Smithwood Ave.				STREET ADDRESS (If rural give location) formerly of 357 Yale Ave.			
3. NAME OF DECEASED: (First) EMMA (Middle) EMILY (Last) EBERT		4. DATE OF DEATH: Oct 30 19 55		5. SEX: female		6. COLOR OR RACE: white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single		8. DATE OF BIRTH: Feb. 14, 1872		9. AGE last birthday: 83 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give work done during most of working life, even if retired: Rtd Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY: self employed		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John C. Ebert		14. MOTHER'S MAIDEN NAME: Margaret Schell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: no	
17. INFORMANT & ADDRESS: Mr. Henry Ebert-701 Woodbourne Ave.							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442.0 Immediate cause (a) Generalized Arteriosclerosis. DUE TO							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 28 Oct 55, 1955, to 54 30 Oct 55, 1955, that I last saw the deceased alive on 28 Oct 55, 1955, and that death occurred at 11:45 A.M. from the causes and on the date stated above. SIGNATURE 219 H. Gatz M.D. ADDRESS 1707 Edmunda Ave, Catonsville 28 Md. DATE SIGNED 30 Oct 55							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 11/2/55		NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
DATE RECD BY LOCAL REGISTRAR 10/24/55		REGISTRAR'S SIGNATURE M. W. F. Edwards		24. FUNERAL DIRECTOR M. J. Dickner & Sons - Balto.		ADDRESS 17 Md.	



9440

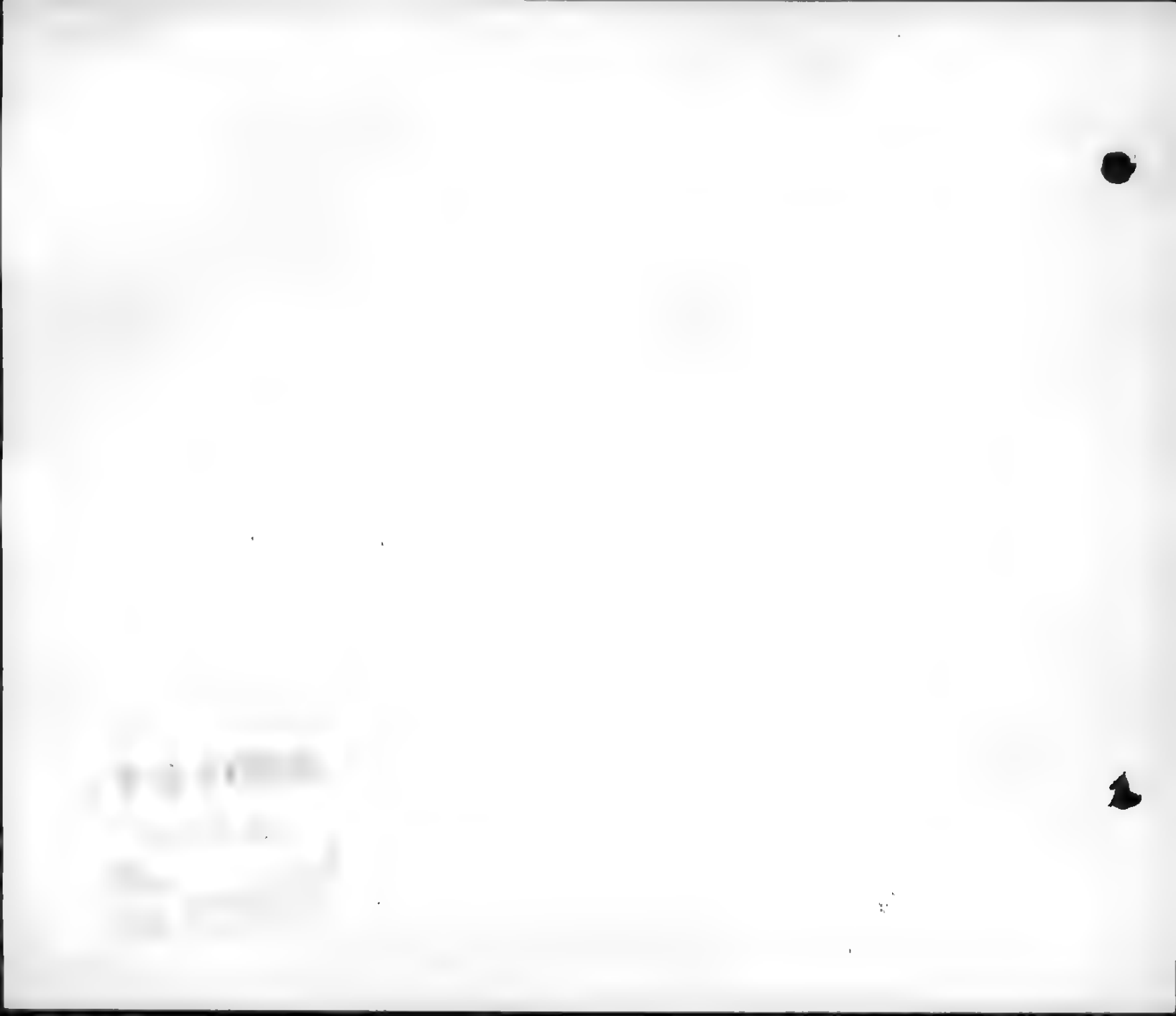
CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Lutherville</u>				OR TOWN <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Road</u>				STREET ADDRESS (If rural give location) <u>York Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Emma Ecker</u>				OF DEATH: <u>Oct. 23, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>Oct. 6, 1869</u>	
9. AGE last birthday: <u>85</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Austria</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME: <u>Joseph Peschke</u>				14. MOTHER'S MAIDEN NAME: <u>Fischer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Family Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>myocardial degeneration</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Semity</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15th Oct., 1955</u> , to <u>23rd Oct., 1955</u> , that I last saw the deceased alive on <u>10/18/1955</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. K. Quinn</u>				ADDRESS <u>York Rd., Timonium</u>		DATE SIGNED <u>10/25/55</u>	
23. BIRTH, CREMATION, REBURY		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 26, 1955</u>		<u>Freemount Cemetery</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 25, 1955</u>		<u>Mabel C. Gray</u>		<u>John Burnia Sons, Towson, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9441

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Item 21 Film G 188 11-9-55 ans

Item 4. FilmG188 10-31-55 et

FOR MEDICAL EXAMINERS

Reg. Dist. No.,

1. PLACE OF DEATH: COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE		MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		FORT HOWARD		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		BALTIMORE		8/11/4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS		1101 N. CAREY STREET		(If rural, give location)		7:35 AM	
3. NAME OF DECEASED (Type or Print)		(First) WILLIAM		(Middle) E.		I EPPS		4. DATE OF DEATH		7:35 AM	
5. SEX MALE		6. COLOR OR RACE COLORED		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) SINGLE		8. DATE OF BIRTH 9-22-95		9. AGE last birthday 60 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) FREDERICKSBURG, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME SAMUEL E. EPPS		14. MOTHER'S MAIDEN NAME EMILY JACKSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		(If yes, give year or dates of service) WW I		16. SOCIAL SECURITY No. Unknown		17. INFORMANT AND ADDRESS CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MD.					

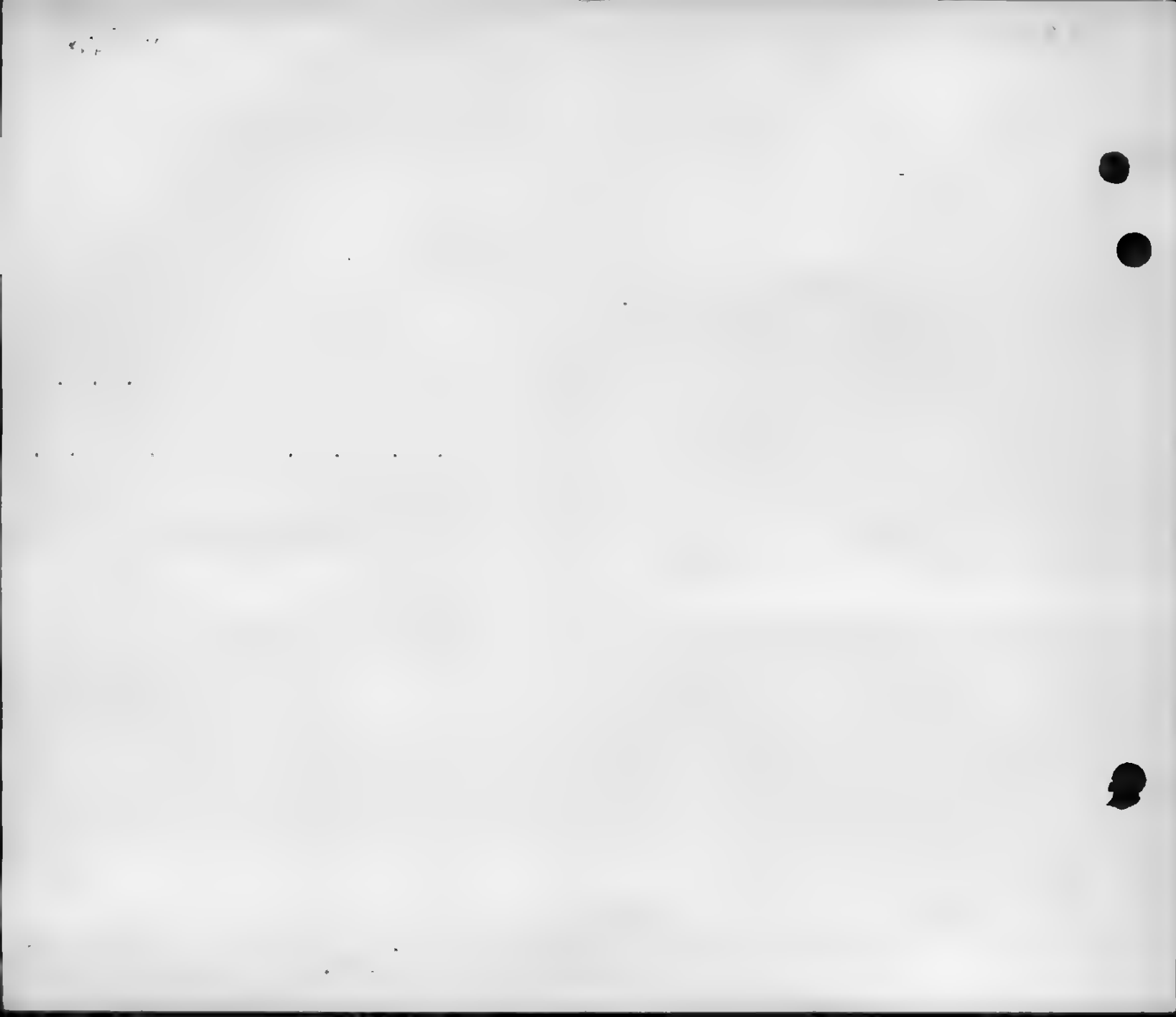
18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
9255 Immediate cause (a) <u>CRUSHING INJURY, CERVICAL SPINAL CORD</u>		6 DAYS	
Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
		20. AUTOPSY?	
		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or elsewhere) OF INJURY <u>In front of home</u> (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10-12-55</u> <u>8</u> p.m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Blacked out and fell on street</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>[Address]</u> DATE SIGNED <u>11/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>BURIAL</u>		<u>10/21/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BALTIMORE NATIONAL</u>		<u>BALTIMORE, MARYLAND</u>	
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Charles R. Law Mortuary, 802-04 Madison Ave Baltimore 1, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

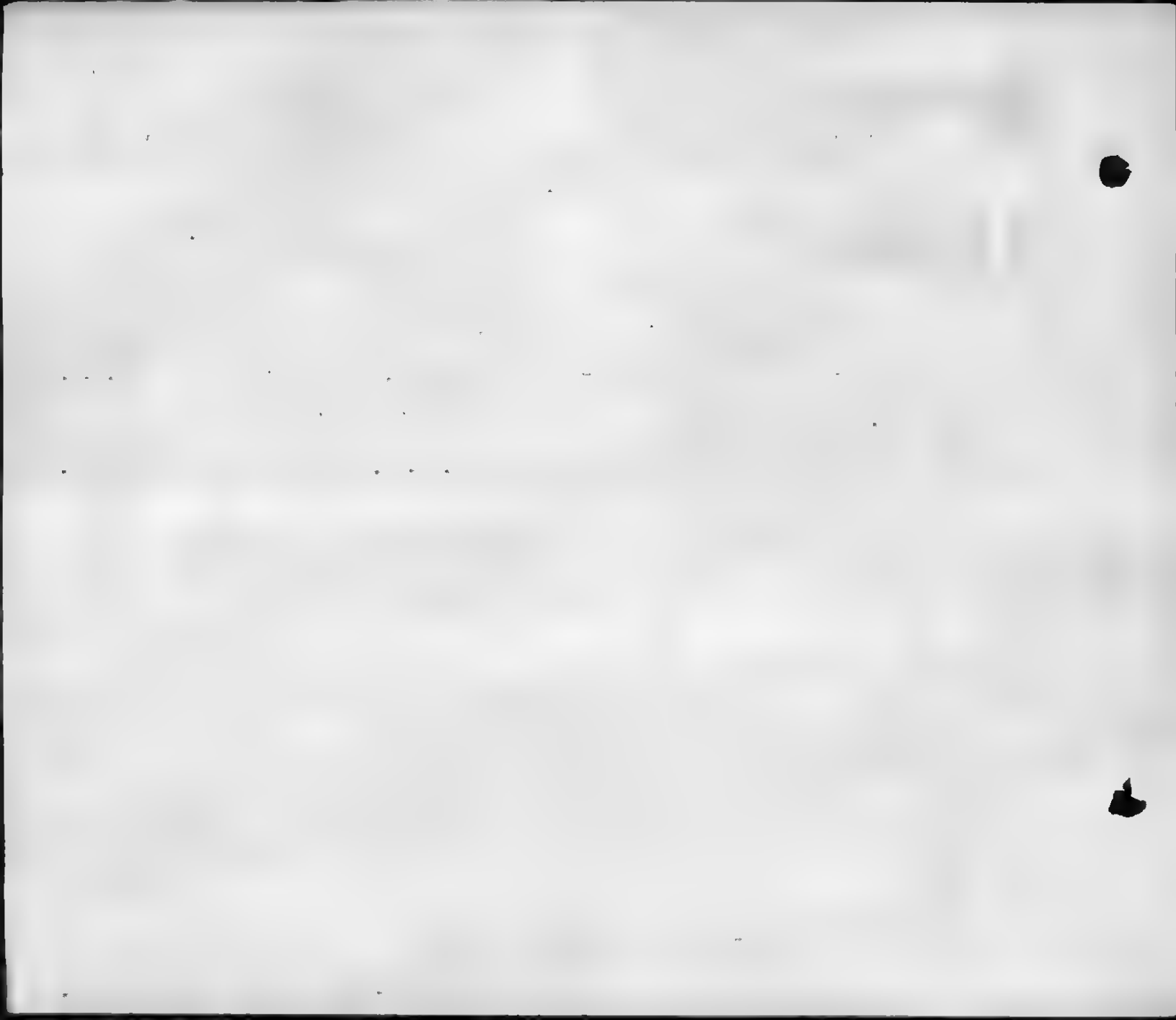
09429

9377

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Turner Station</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Turner Station</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>710 Avondale Road</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Turner Station</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location) <u>710 Avondale Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Joseph William Everett</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>22</u> <u>19 55</u>				
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>-----</u>	8. DATE OF BIRTH: <u>June 11, 1946</u>		9. AGE last birthday: <u>9</u> yrs IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>-----</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-----</u>		11. BIRTHPLACE (State or foreign country): <u>Gastonia, North Carolina</u>			
13. FATHER'S NAME: <u>James M. Everett</u>			14. MOTHER'S MAIDEN NAME: <u>Bertha Truitt</u>				
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Rev. J. A. Everett 710 Avondale Rd.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>237X</u>				<u>1 wk.</u>			
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>3 w.</u>			
(A) <u>Hypertension + uremia</u>				<u>5 yrs.</u>			
(B) <u>Renal failure</u>							
(C) <u>Brain tumor</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-14, 1954</u> , to <u>12-22, 1955</u> , that I last saw the deceased alive on <u>12-22, 1955</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harold Tucker</u>		ADDRESS <u>South Co. 2</u>		DATE SIGNED <u>10-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>			
				LOCATION (City, town, or county) (State) <u>Murkirk, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Oct 25-1955</u>		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		24. FUNERAL DIRECTOR <u>Charles R. Law</u>			
				ADDRESS <u>802-04 Madison Ave.</u>			



9442

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

09430

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bethlehem Steel Corporation				STREET ADDRESS 242 N. Monroe Street		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) Maynard		(First) Ernseliff		(Last) Falden		4. DATE (Month) (Day) (Year) OF DEATH 10 27 19 55	
5. SEX M		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated		8. DATE OF BIRTH January 1, 1897	
						9. AGE last birthday 58 yrs. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Danville, Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles H. Falden				14. MOTHER'S MAIDEN NAME Anna L. Fitzgerald			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) I		17. INFORMANT AND ADDRESS Verba F. Dersey 1516 McCulloch St.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Pulmonary Occlusion

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE, WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY

Yes ☐ No ☒TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not while
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

21. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

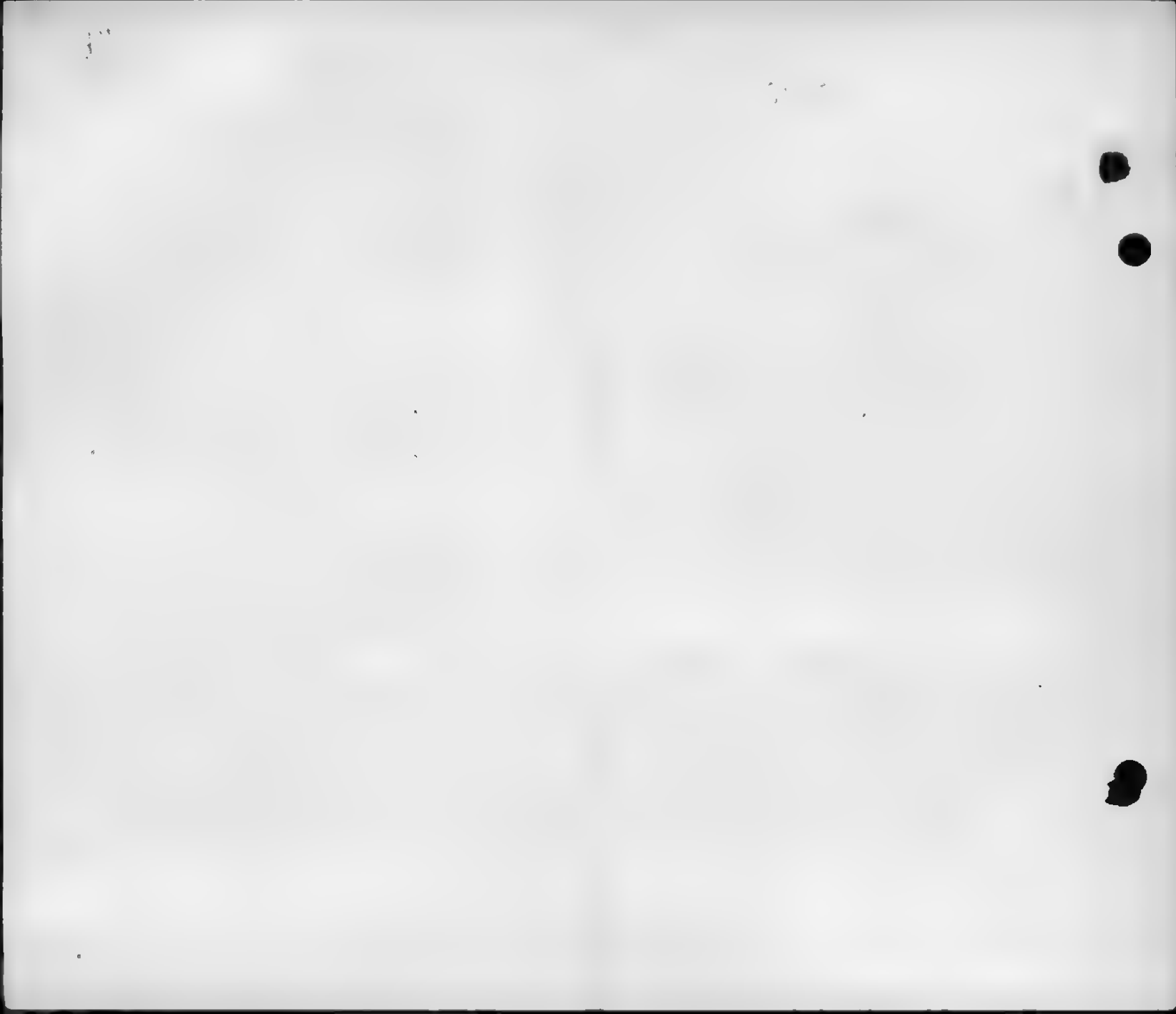
24. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802-04 Madison Ave.

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09431

9443

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>L.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>Ruxton</u>				TOWN <u>Balto.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Home</u>				STREET ADDRESS (If rural give location) <u>2102 South Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>HELEN S. FERTIG</u>				<u>Oct. 8, 19 55</u>			
5. SEX. <u>female</u>		6. COLOR OR RACE. <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>		8. DATE OF BIRTH: <u>June 2, 1892</u>	
				9. AGE last birthday: <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mln.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				12. KIND OF BUSINESS OR INDUSTRY: <u>at Home</u>			
13. FATHER'S NAME: <u>Albert Leech</u>				14. MOTHER'S MAIDEN NAME: <u>Janet Rlerson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mr. Kenneth W. Fertig - 2102 South Rd.</u>			
17. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>197.1</u>							
IMMEDIATE CAUSE (A) <u>Inoperable carcinoma (pelvic)</u>				<u>about 1 year</u>			
ANTECEDENT CAUSE (B) <u>Internal Hemorrhage</u>				<u>about 2 hours</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Cessation of all bodily functions</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardio-vascular Disease</u>				<u>about 15 years</u>			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 18, 1955</u> , to <u>Oct. 8, 1955</u> , that I last saw the deceased alive on <u>Oct. 3, 1955</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Amal S. M...</u>				ADDRESS <u>616 Cathedral St.</u>		DATE SIGNED <u>Oct. 8, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Kensico Cem.</u>		LOCATION (City, town, or county) (State) <u>Valhalla, N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Michael...</u>		24. FUNERAL DIRECTOR <u>Wm. J. Lickens & Sons</u>		ADDRESS <u>Balto 17</u>	

THE UNIVERSITY OF CHICAGO

1910

9390

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u>		STATE <u>Md.</u> COUNTY <u>Balt.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u>	
TOWN <u>10</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		ADDRESS <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Craddock Home</u>							
3. NAME OF DECEASED: (Type or Print) <u>Robert Emmett Links</u> (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 8, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Caucasian</u>		7. SINGLE MARRIED. WIDOWED. DIVORCED. <u>Married</u>		8. DATE OF BIRTH: <u>Aug. 14, 1885</u> 70 yrs.	
9. AGE last birthday: <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		11. CITIZEN OF WHAT COUNTRY?			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Plumber</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Plumber</u>			
13. FATHER'S NAME: <u>Edward B. Links</u>				14. MOTHER'S MAIDEN NAME: <u>Ida B. Links</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1931 2121 1111</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Emily S. Links</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
334-X IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Hemiplegia</u>							
(B) <u>Bed Sores, + General weakness</u>							
(C) <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-23, 1954</u> to <u>10-8, 1955</u> that I last saw the deceased alive on <u>10-7, 1955</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thos. Woolridge</u>		M. D. <u>R. B. 212</u>		DATE SIGNED <u>Oct 27 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Oct. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-12-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>1031 K Street N.W. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09433

9444

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spawass Pt 19 tw</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spawass Pt 19</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>820 5th Street</u>	
3. NAME OF DECEASED (Type or Print) <u>John Cherry Finney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 7th 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SPECIAL STATUS <u>WIDOWED</u>	8. DATE OF BIRTH <u>April 12 1863</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shut Mills</u>	9. AGE last birthday <u>92 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>2-006-0298</u>	
17. INFORMANT AND ADDRESS <u>Mamie White</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

47 Immediate cause (a) Lobar pneumonia

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1st, 1955, to Oct 7th, 1955, that I last saw the deceased alive on October 7th, 1955, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

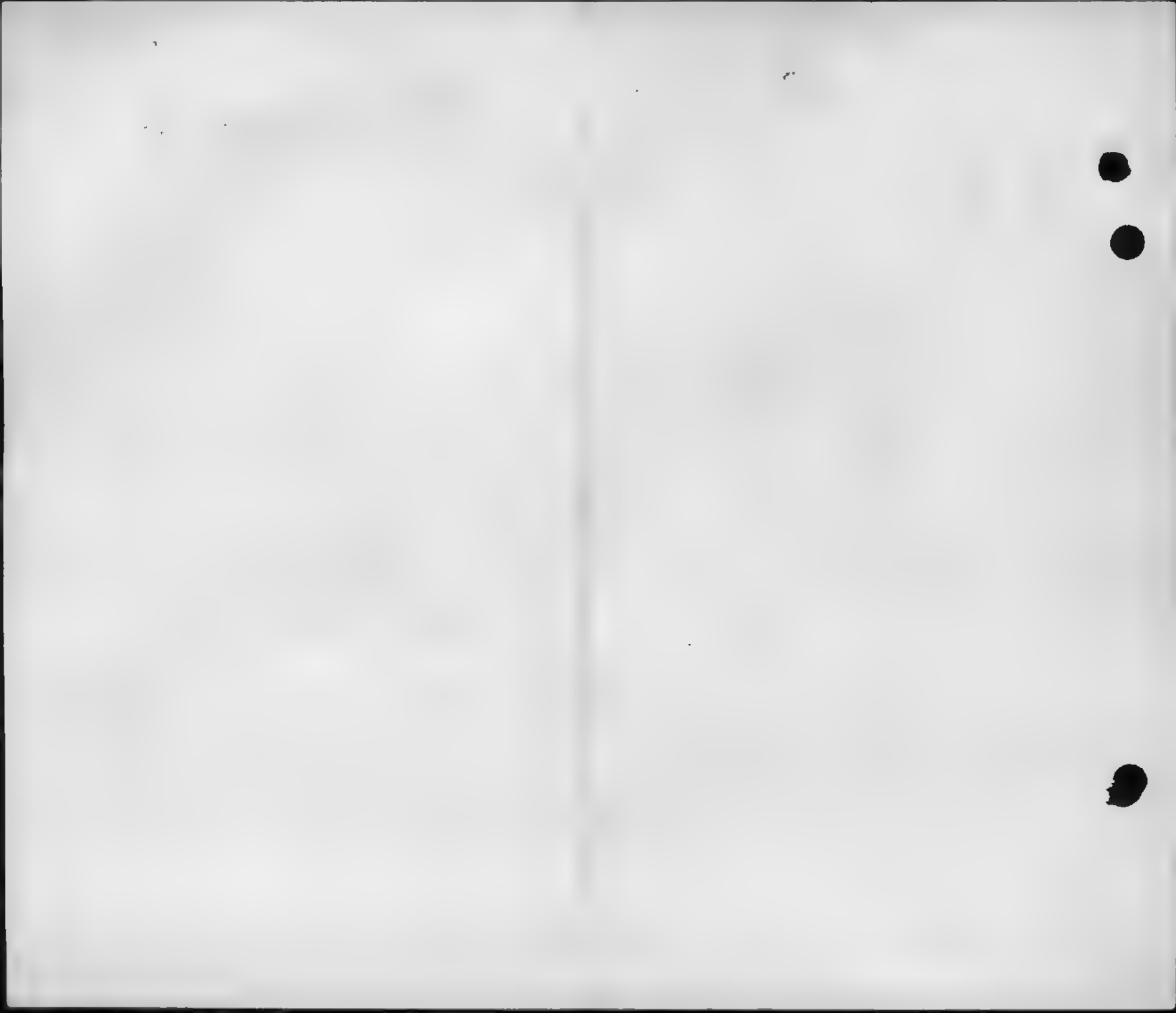
DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>10-11-55</u>	<u>Mt. Calvary</u>	<u>AA Co. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>October 8th 1955</u>	<u>R.W.</u>	<u>Charles R. Law</u>	<u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



9445

CERTIFICATE OF DEATH

Reg. Dist. No. *22*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 20 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 633 WEST FRANKLIN STREET			
3. NAME OF DECEASED: (First) WILLIAM		(Middle) (NMI)		(Last) FISHER (Willie)		4. DATE (Month) (Day) (Year) OF DEATH OCTOBER 16, 19 55	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: 7/12/05	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY BETH. STEEL CO.		11. BIRTHPLACE (State or foreign country): BLACKSTOCK, S. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: ALEX FISHER				14. MOTHER'S MAIDEN NAME: ROSE BLACKMORE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WW II		16. SOCIAL SECURITY No. Unknown		17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) LUPUS ERYTHEMATOSIS							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 26, 19 55 , to OCT. 16, 19 55 , and that death occurred at 11:00 M. , from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIFF, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND 10-17-55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10/20/55		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-18-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR CHARLES R. LAW MORTUARY		ADDRESS 802-OL MADISON AVE. BALTIMORE 1, MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10/1/21

1

10/1/21

10/1/21



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

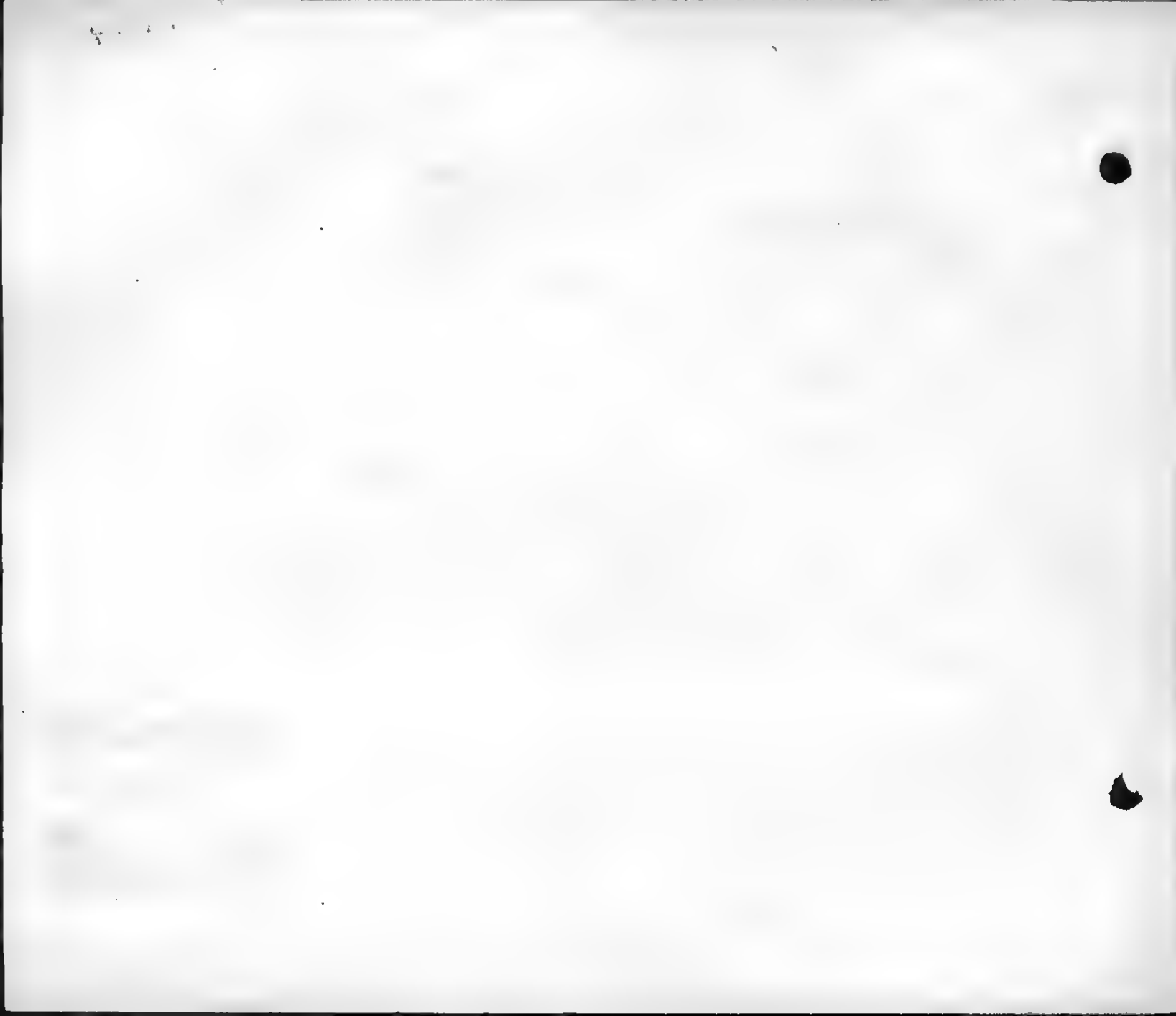
10506

9446

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>2018 W. North Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>Margaret</u> <u>Flanigan</u>		<u>October 31,</u> <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>2-28-1871</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>84 yrs.</u>		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Flanigan</u>		<u>Catherine McGlennon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>Unknown</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Records Spring Grove State Hospital</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>		<u>Years</u>	
ANTECEDENT CAUSE (B) <u>Malnutrition</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Dehydration</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-</u> , <u>1953</u> , to <u>10-31-</u> , <u>19 55</u> that I last saw the deceased alive on <u>10-31-</u> , <u>19 55</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Suzanne Wachter</u>		DATE SIGNED <u>10-31-55</u>	
ADDRESS <u>Spring Grove State Hospital</u>		M. D. <u>Catonsville 28, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>NOV 3-55</u>	
NAME OF CEMETERY OR CREMATORY <u>U.S. MEDICAL SCHOOL</u>		LOCATION (City, town, or county) (State) <u>29 S. GREEN ST</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
REGISTRAR'S SIGNATURE <u>Victor S. Harris</u>		<u>Woffel Bros 1700 FLEMING ST</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09435

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville	LENGTH OF STAY (in this place) 24 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital		STREET ADDRESS (If rural give location) Cathedral and Madison Sts.	
3. NAME OF DECEASED: (First) Charles (Middle) A. (Last) Frannie Frainig		4. DATE (Month) (Day) (Year) OF DEATH October 7, 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: 8-8-1902
9. AGE last birthday 53 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 4	11. IF UNDER 24 HRS. Hours 1 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Keeper Building Construction		10B. KIND OF BUSINESS OR INDUSTRY: Maryland	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Frank Frannie Frainie		14. MOTHER'S MAIDEN NAME: Margaret Schneider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 331X			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Cerebrovascular accident			
(B) Cerebral arteriosclerosis			
(C) Generalized arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-13- , 19 55 , to 10-7- , 19 55 , that I last saw the deceased alive on 10-7- , 19 55 , and that death occurred at 4:25PM , from the causes and on the date stated above.			
SIGNATURE Stella Wachler		ADDRESS Spring Grove State Hospital DATE SIGNED 10-7-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/10/55	
NAME OF CEMETERY OR CREMATORY Holy Redeemer		LOCATION (City, town, or county) (State) Baltimore Maryland	
DATE REC'D BY LOCAL REGISTRAR Oct 8, 1955		REGISTRAR'S SIGNATURE R.W.	
24. FUNERAL DIRECTOR H. H. Mearns & Son 805 N. Calvert St.		ADDRESS	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

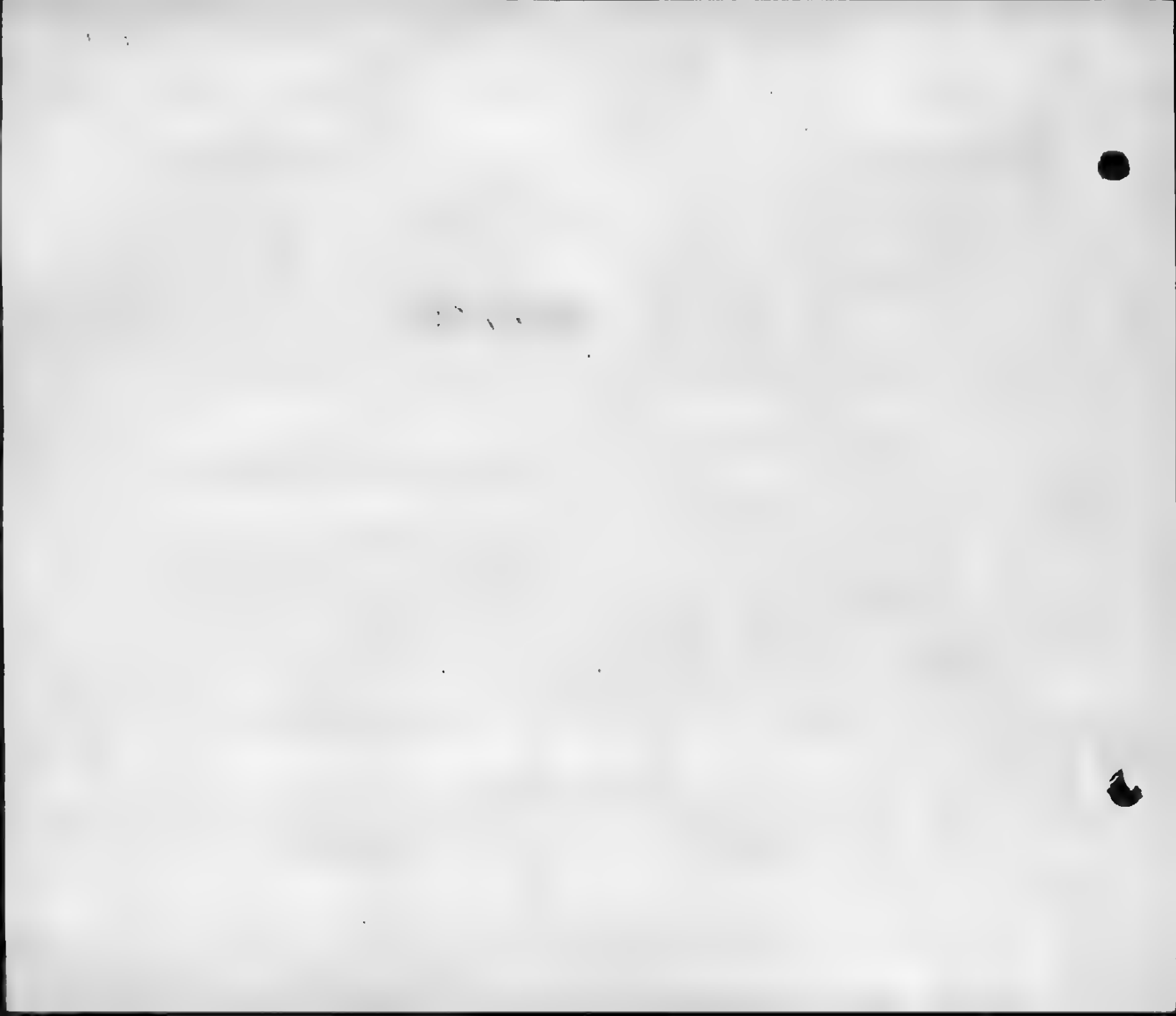
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09436

9448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>Catonsville</i>		LENGTH OF STAY (in this place) <i>Since Feb 24 1955</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i> <i>31.14</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Song Grove State Hospital</i>				STREET ADDRESS (If rural give location) <i>2628 Park Heights Terrace</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>BERTHA - GARFINKEL</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>10 16 1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>1905</i>	
				9. AGE last birthday <i>50</i> yrs		IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>		11. BIRTHPLACE (State or foreign country): <i>VTA Baltimore, Md</i>	
13. FATHER'S NAME: <i>Abraham Abrams</i>				14. MOTHER'S MAIDEN NAME: <i>Sara</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>na</i>		17. INFORMANT & ADDRESS: <i>Mr. Harry Garfinkel - 2628 Park Heights Terrace</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <i>Diabetes</i>							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Chronic Brain Syndrome</i>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 9th, 1955</i> , to <i>10/16, 1955</i> , that I last saw the deceased alive on <i>10/16, 1955</i> , and that death occurred at <i>8:25 p M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Rena Becker</i>				M. D. <i>Song Grove State Hosp.</i> DATE SIGNED <i>10/16/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10/18/55</i>		NAME OF CEMETERY OR CREMATOR <i>Suburtyz Masach Ari</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24. FUNERAL DIRECTOR <i>Sol Gersman & Sons Inc.</i>		ADDRESS <i>1124-2671 North</i>	



Reg. Dist. No. 44

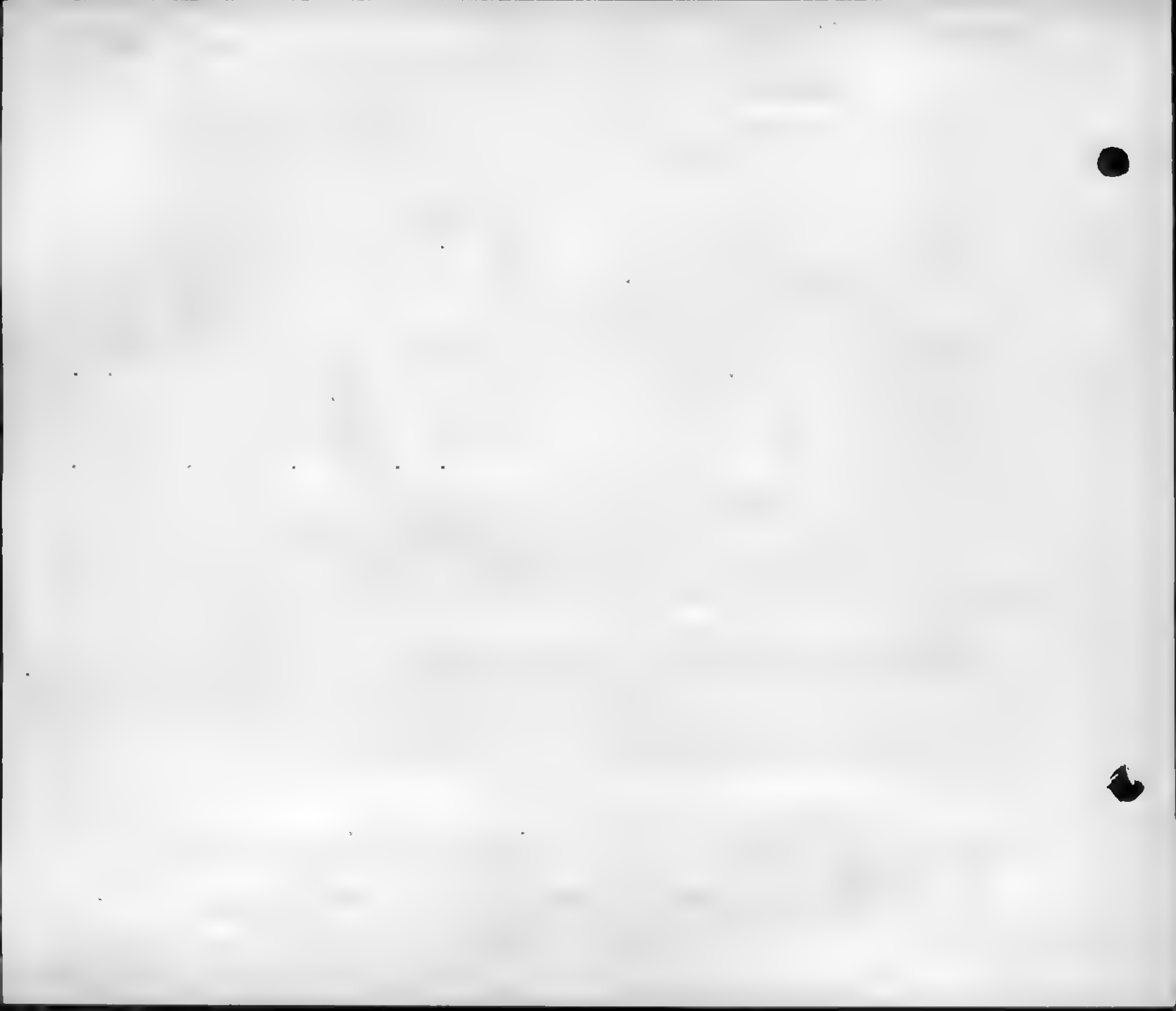
9449

MARGIN RESERVED FOR BINDING

U.S. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (Home) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u>	LENGTH OF STAY (in this place) <u>1 DAY</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>305 S. ROBINSON STREET</u>	
3. NAME OF DECEASED: (First) <u>THOMAS</u> (Middle) <u>A.</u> (Last) <u>GARNER SR.</u>		4. DATE OF DEATH: (Month) <u>OCTOBER</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>1/26/79</u>
9. AGE last birthday: <u>76</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN - Ret. City Police</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u> </u>	
11. BIRTHPLACE (State or foreign country): <u>DANVILLE, VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>ARCHER GARNER</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZABETH YANCY</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>SAW</u>		16. SOCIAL SECURITY NO. <u>214-26-7256</u>	
17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>451X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>(A) DISSECTING ABDOMINAL ANEURYSM</u> <u>(B) ARTERIOSCLEROSIS</u> <u>(C) </u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>UNKNOWN</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARCINOMA, PROSTATE</u>		<u>3 - 4 YRS.</u>	
19A. DATE OF OPERATION: <u> </u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21A. PLACE (Home, farm, factory, street, office bldg., etc.)		21B. WHERE DID (City or town) (County) (State)	
21C. TIME (Month) (Day) (Year) (Hour) OF INJURY		21D. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21E. HOW DID INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
2. I hereby certify that <u>VA</u> attended the deceased from <u>OCT. 3, 1955</u> , to <u>OCT. 4, 1955</u> , that last saw the deceased <u> </u> and that death occurred at <u>12:30PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Francis G. Dickey, Chief Medical Service</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>	
DATE SIGNED <u>10-4-55</u>		23. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>	
23. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		24. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOMES, 4210 BELAIR ROAD BALTIMORE, MD.</u>	



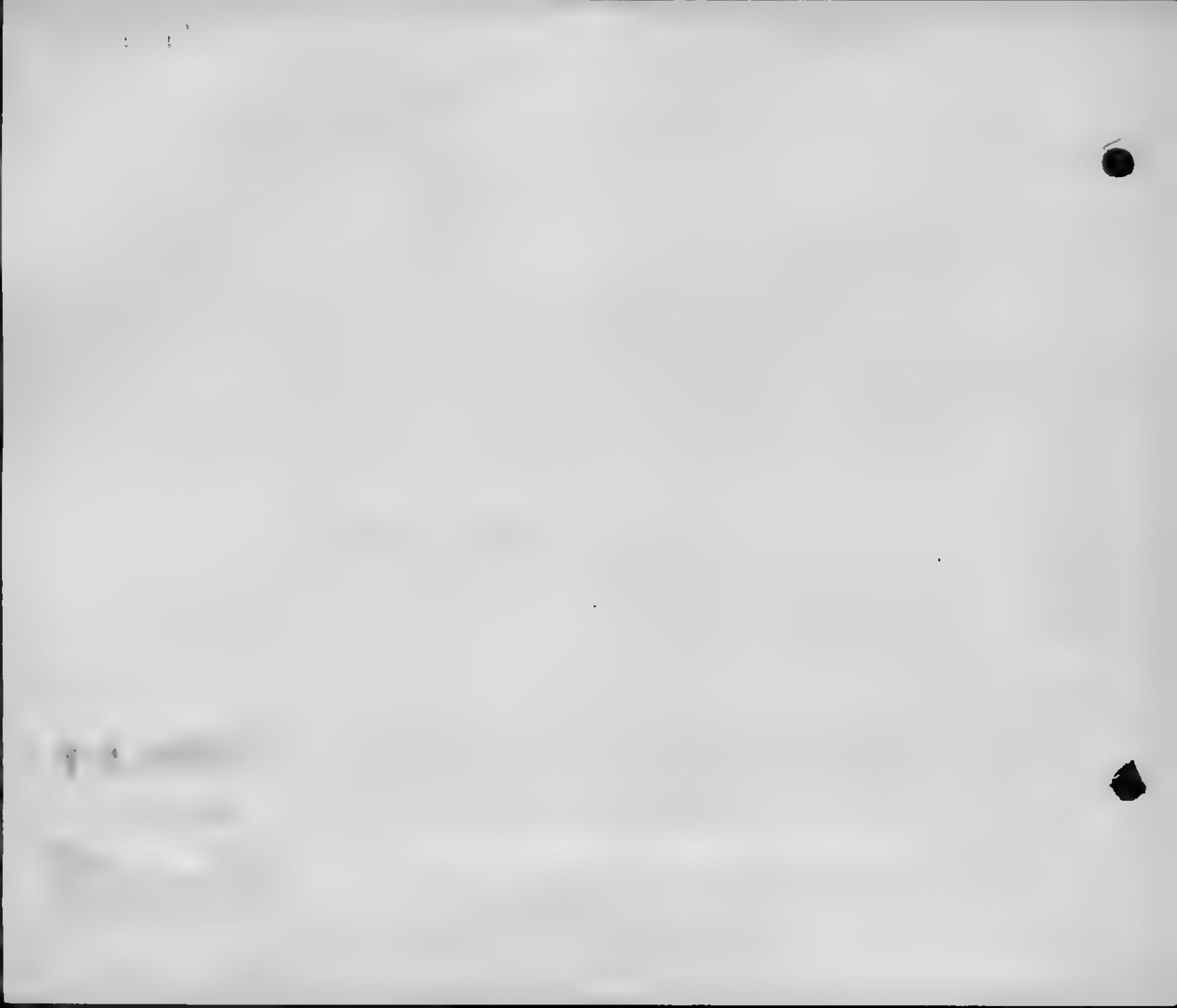
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9450

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

09438

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>West Va.</i>	COUNTY <i>Putnam</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Cathartsville, Md.</i>	LENGTH OF STAY (in this place) <i>2 wks.</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Wardensville W. Va.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>478 #7 Old Court Rd.</i>		STREET ADDRESS (If rural, give location) <i>85 X 3 J</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <i>SUSAN REBECCA GODLOVE</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Oct 16 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>July 31, 1872</i>
9. AGE last birthday: <i>83</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Own home West Va.</i>	
11. BIRTHPLACE (State or foreign country): <i>W.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>W.S.A.</i>	
13. FATHER'S NAME: <i>Oscar White</i>		14. MOTHER'S MAIDEN NAME: <i>Marg. Murray</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY No.: <i>None</i>	
17. INFORMANT & ADDRESS: <i>Mrs. Marg. Spilman (daughter)</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
422.2 Immediate cause (a)..... <i>Chor. Myocarditis</i>		10 yrs.	
Antecedent cause(s) (b)..... <i>Chor. Choleocystitis & Lithiasis</i>		3 yrs.	
Diseases or conditions, if any, giving rise to the above cause (c)..... <i>Arthritis</i>			
stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		10-15 yrs	
19a. DATE OF OPERATION: <i>None</i>		19b. MAJOR FINDING OF OPERATION: <i>None</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: <i>None</i>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>None</i>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>None</i> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>None</i>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>D.D. Caples</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <i>10-16-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>		DATE THEREOF: <i>Oct 19, 1955</i>	
NAME OF CEMETERY OR CREMATORY: <i>Wardensville</i>		LOCATION (City, town, or county) (State): <i>West Virginia</i>	
24. FUNERAL DIRECTOR: <i>Stover Stranburg, VA.</i>		ADDRESS: <i>Stover Stranburg, VA.</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

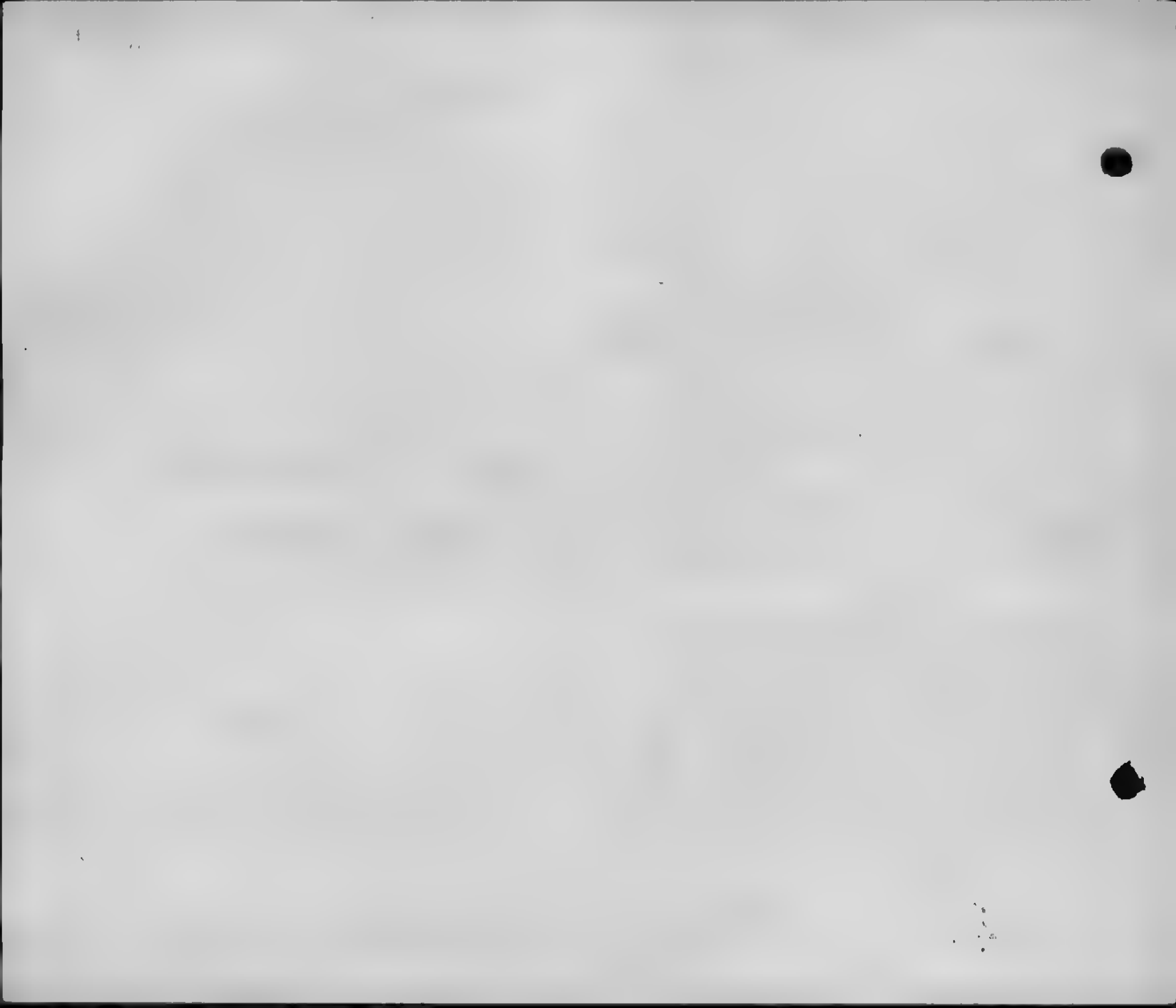
9451

09439
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 28

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Riderwood		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorenson Nursing Home				STREET ADDRESS (If rural, give location) 1521 E. 28th Street			
3. NAME OF DECEASED: (Type or Print) JAMES		(First) D.		(Middle) GOLDRICK		4. DATE OF DEATH (Month) 10 (Day) 19 (Year) 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: June 27, 1875	9. AGE last birthday: 80 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Ret. Loan Office			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: ?				14. MOTHER'S MAIDEN NAME: ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		15. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Wm. Mc Callister, 1521 E. 28th Street	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
4201 Immediate cause (a) Arteriosclerotic cardiovascular disease DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Wm. W. Ruck</i>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/19/55		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 10/22/1955		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. 10/20/55		REGISTRAR'S SIGNATURE <i>Wm. W. Ruck</i>		24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road		ADDRESS #14	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09440
Reg. Dist.

No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY BALTO.			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN DUNDALK 22		3 YRS		TOWN Baltimore DUNDALK 22			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave. West of North Point Road				STREET ADDRESS (If rural, give location) 7358 Manchester Road			
3. NAME OF DECEASED: (First) Irvin		(Middle) STEPHEN		(Last) GONSCHOR		4. DATE OF DEATH (Month) (Day) (Year) October 14 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): DIVORCED	8. DATE OF BIRTH: 17 SEPT 1922		9. AGE last birthday: 33 yrs.	IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): CHECKER		10b. KIND OF BUSINESS OR INDUSTRY: STEEL MFGR		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOHN GONSCHOR				14. MOTHER'S MAIDEN NAME: FELICIA BURAZZINSKI			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 214-16-9684		17. INFORMANT & ADDRESS: FELICIA GONSCHOR - SAME ADDRESS			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Hemoperitoneum secondary to Ruptured Spleen Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street		21c. (City or town) (County) 03 Baltimore (State) Maryland			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Speeding auto - cut of control			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Miller		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		DATE SIGNED 10/14/55	
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF 10-18-55		NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY		LOCATION (City, town, or county) (State) BALTO. CO., MD.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE Edith Harley		24. FUNERAL DIRECTOR White, Rufe Bradley, Dundalk, Md.		ADDRESS	



1

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09441

9379

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>DUNDALK 22</u>		<u>22 YRS.</u>		TOWN <u>DUNDALK 22</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Ventnor Terrace</u>				STREET ADDRESS (If rural give location) <u>133 VENTNOR TERRACE</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANKLIN HARRISON GRAMMER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10-28-1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u>		8. DATE OF BIRTH <u>OCT. 17, 1891</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL PLANT</u>		9. AGE last birthday <u>64</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>GEORGE W. GRAMMER</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				14. MOTHER'S MAIDEN NAME <u>ANNIE E. EBBERT</u>		16. SOCIAL SECURITY NO. <u>215-16-5115</u>	
17. INFORMANT & ADDRESS <u>VELMA ALBRECHT - SAME</u>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
162X IMMEDIATE CAUSE (A) <u>BRONCHogenic CA.</u>						<u>1 Year</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-24</u> , 19 <u>55</u> , to <u>10-28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-25</u> , 19 <u>55</u> , and that death occurred at <u>11:55</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Carl O'Brien</u>				DATE SIGNED <u>10-30-55</u>			
ADDRESS (Street, city, town, state) <u>M.D. 21 Kim hip Rd Dundalk 22</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>10-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>BT. PAULS</u>		LOCATION (City, town, or county) (State) <u>MATTHEW, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William M. Hooper</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Bentley</u>		ADDRESS <u>Headth, Md.</u>	
DATE <u>Oct 30-1955</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **09442**
9452 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryla		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN) Catonsville		LENGTH OF STAY (in this place) 19 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove Hospital				STREET ADDRESS (If rural give location) 3406 Keene Avenue			
3. NAME OF DECEASED: ANNA (First) BLANCHE (Middle) GREEN (Last)				4. DATE (Month) (Day) (Year) OF DEATH: 10 4 19 55			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: 10-25-1868	9. AGE last birthday: 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: (?) Nooley				14. MOTHER'S MAIDEN NAME: (?) Coggins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Harvey Green 5318 Plymouth Rd. Balto, Md	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 450.0 Generalized Arteriosclerosis							
ANTECEDENT CAUSE (B) Senile Psychosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 1903.71 (C) Malnutrition and Dehydration							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? Catonsville Maryland			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY June 27, 1955 M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Slipped and fell			
22. I hereby certify that I attended the deceased from June 17, 1936 to Oct 4 , 19 55 , that I last saw the deceased alive on Oct 4 , 19 55 , and that death occurred at 7:30 A.M. , from the causes and on the date stated above.							
SIGNATURE Spring Grove Hospital		DATE 10/4/55		M. D.		DATE SIGNED 10/4/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE OF BURIAL 10/6/55		NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		LOCATION (City, town, or county) (State) BALTO, MD.	
DATE REC'D BY LOCAL REGISTRAR 10/5/55		REGISTRAR'S SIGNATURE Dr. H. H. H. H. H.		24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Vayford Rd.	



9453

09443

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

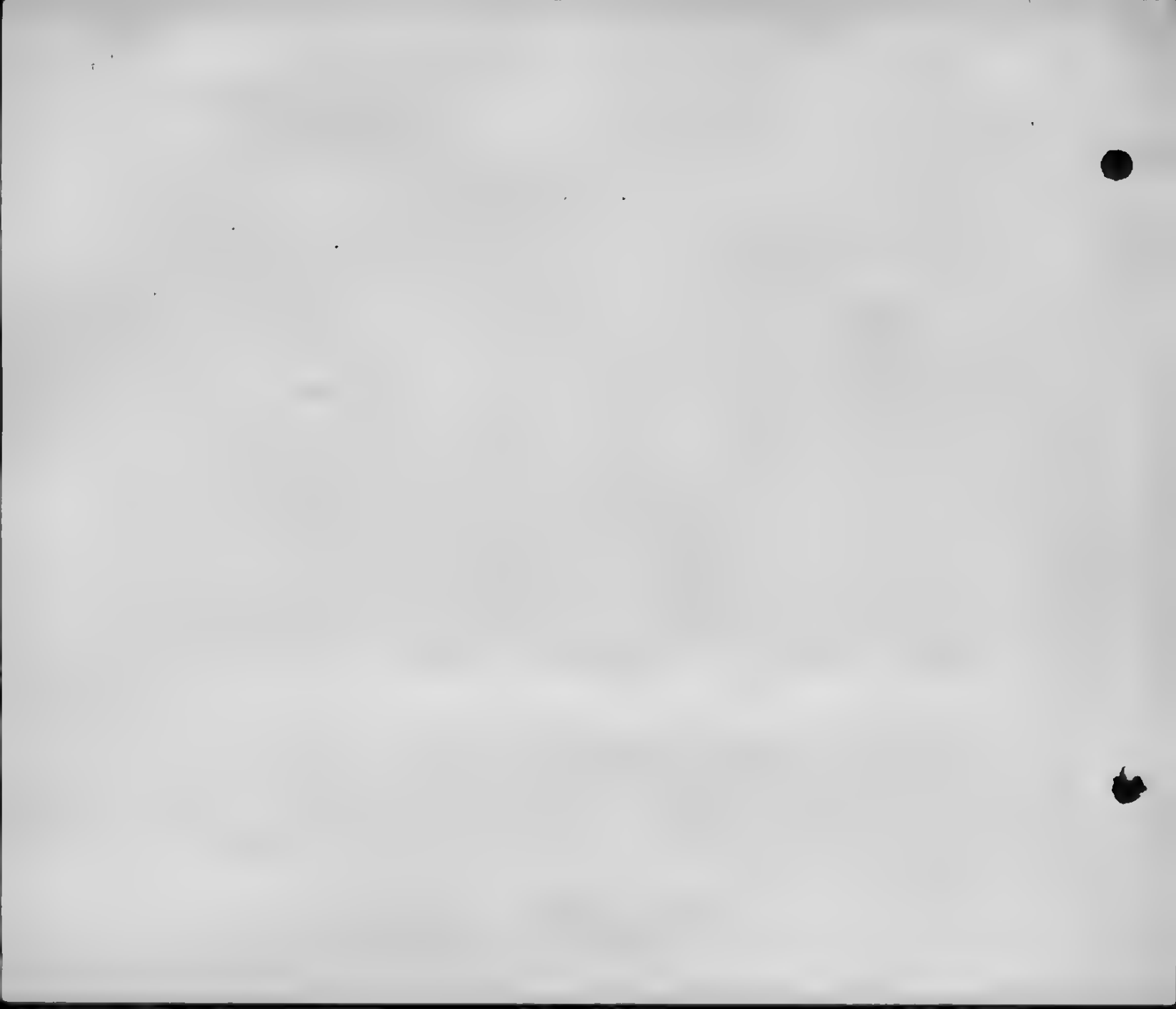
No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore	MARYLAND		STATE Maryland	COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville	LENGTH OF STAY (In this place) 8yr.2mos.27days	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital			STREET ADDRESS (If rural, give location) 1628 N. Durham Street		
3. NAME OF DECEASED: (First) (Middle) (Last) Robert Griffin			4. DATE OF DEATH (Month) (Day) (Year) October 27, 19 55		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 8-19-1871	9. AGE last birthday: 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Plasterer		10b. KIND OF BUSINESS OR INDUSTRY: Contractor	11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Griffin			14. MOTHER'S MAIDEN NAME: Susan Will		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown		16. SOCIAL SECURITY No.: Unknown	17. INFORMANT & ADDRESS: Records Spring Grove State Hospital		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.0 Immediate cause (a) ... Acute cardiac failure. DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) Generalized arteriosclerosis					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town, (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>Gen. M. Kieffer</i>		1010 Leaden		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. M. D. 10-27-55	
23. BURIAL, CREMATION, REMOVAL (Specify): burial	DATE THEREOF 10/31/55	NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. 1/28/56	REGISTRAR'S SIGNATURE <i>M. C. Hedrick</i>	24. FUNERAL DIRECTOR Wm. Book, Jr.		ADDRESS 1217 St. Paul Street	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09444

9454

CERTIFICATE OF DEATH

Reg. Dist. No. 605

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>	
TOWN <u>MIDDLE RIVER</u>		TOWN <u>MIDDLE RIVER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>AT HOME</u>		STREET ADDRESS (If rural, give location) <u>814 WAMPLER Rd</u>	
3. NAME OF DECEASED (First) <u>JAMES</u> (Middle) <u>STANISLAUS</u> (Last) <u>GRUSZ</u>		4. DATE OF DEATH (Month) <u>OCT</u> (Day) <u>8</u> (Year) <u>1953</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>NOV-26-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EASTERN ROLLING-MILL</u>	11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
13. FATHER'S NAME <u>JOSEPH GRUSZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>216-10-0743</u>	17. INFORMANT AND ADDRESS <u>ANNA J GRUSZ 814 WAMPLER Rd</u>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arterio-sclerotic Cardio-vascular Disease</u>			<u>2 yrs</u>
Antecedent cause(s) (b) <u>Arterio-sclerotic Gangrene of Foot</u>			<u>2 mo</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>NO</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1st</u> , 1953, to <u>Oct. 8</u> , 1953, that I last saw the deceased alive on <u>Oct. 8</u> , 1953, and that death occurred at <u>3:30</u> A.m., from the causes and on the date stated above.			
SIGNATURE <u>James J. White M.D.</u>		DATE SIGNED	
422 Eastern Ave. Baltimore 21, Md			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>OCT. 11-1953</u>	
NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		LOCATION (City, town, or county) <u>BALTIMORE, Md</u>	
1300 DUNDALK AVE			
24. FUNERAL DIRECTOR <u>George A. Weber</u>		ADDRESS <u>705 S. Ann. St.</u>	

100 100 100



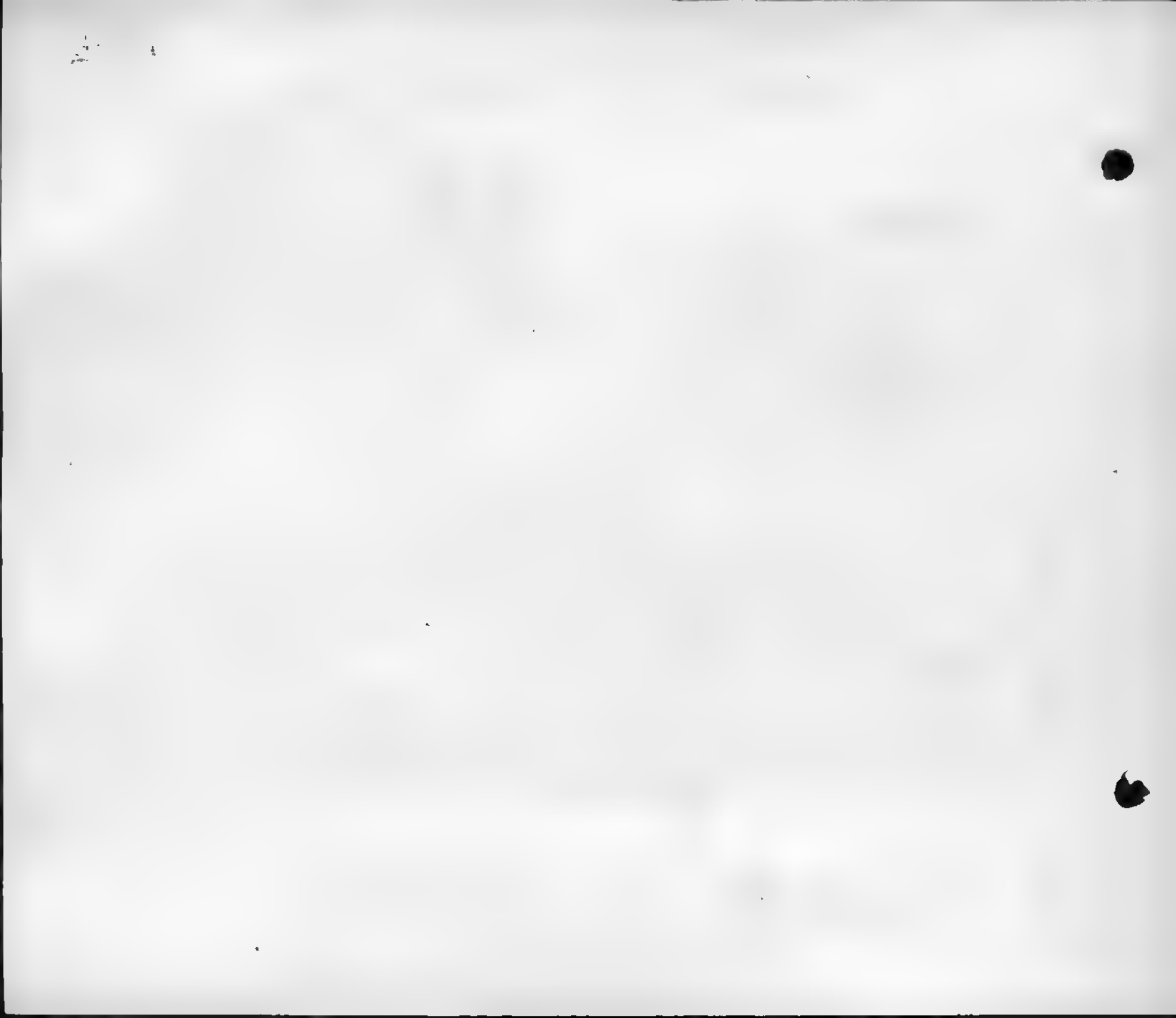
9455
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 Oella Ave.</u>				STREET ADDRESS (If rural give location) <u>109 Oella Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>JOHN</u> <u>M.</u> <u>HAHN</u>				OF DEATH: <u>Oct.</u> <u>25,</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Dec. 4, 1894</u>	<u>60</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Electrician</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Edward Hahn</u>				14. MOTHER'S MAIDEN NAME: <u>Adda Ott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>yes</u> (If Yes, give war or dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>214-05-8856</u>		17. INFORMANT & ADDRESS: <u>Catonsville, Md.</u> <u>Mrs. Marian A. Hahn - 109 Oella Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
196X IMMEDIATE CAUSE (A) <u>Cerebral Embolism</u>						<u>1 day</u>	
ANTECEDENT CAUSE (B) <u>Metastatic Adenoma 2nd L. Ventilation</u>						<u>6 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-13</u> , 19 <u>55</u> , to <u>10-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John H. Gallagher</u>		ADDRESS <u>M.D. Catonsville 28 Md.</u>		DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/28/55</u>		<u>Loudon Park</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>10/28/55</u>		<u>John H. Gallagher</u>		<u>John J. Dickener & Sons - Balto.</u>		<u>17 Md.</u>	

MARGIN RESERVED FOR FINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

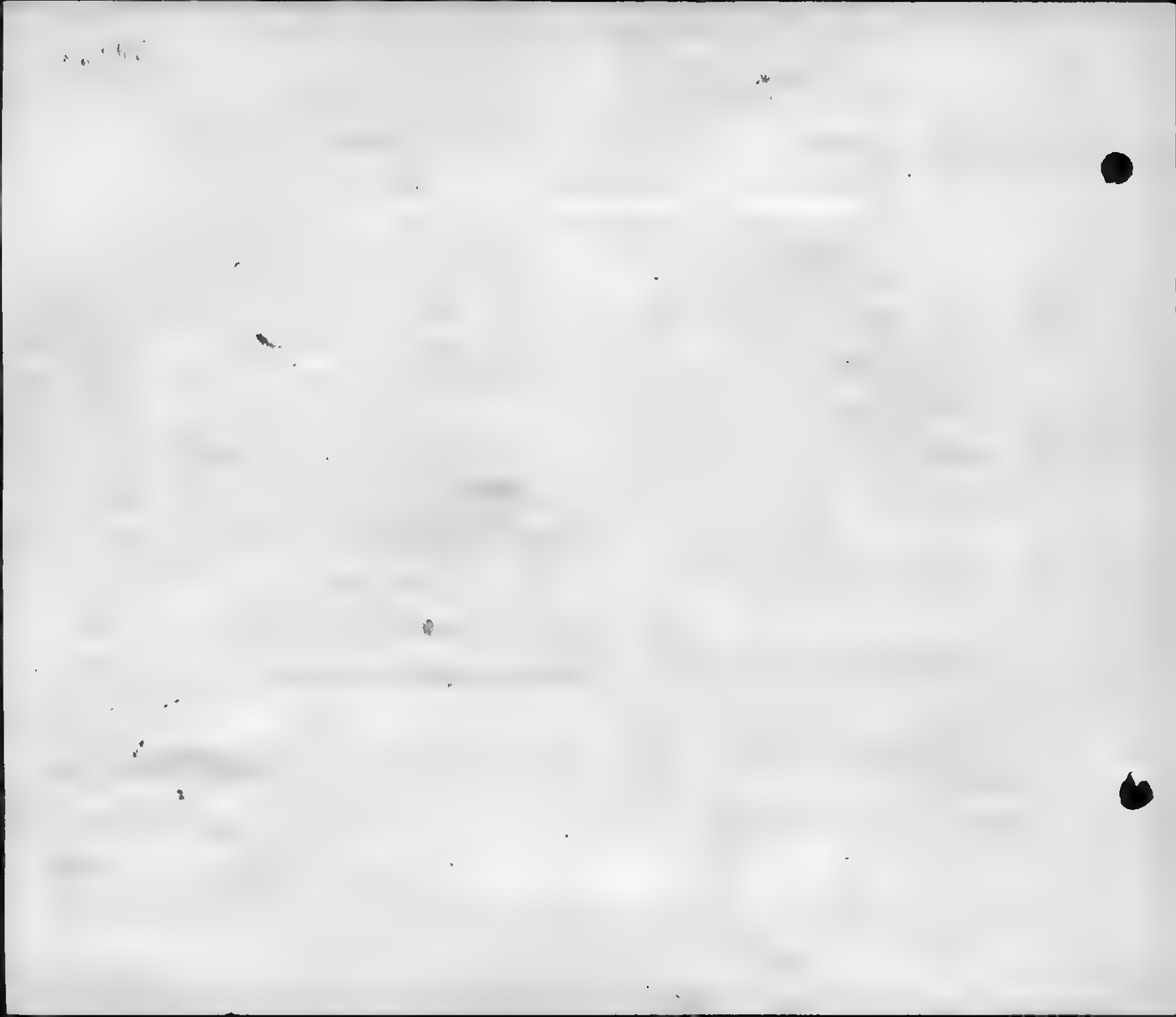


9456

CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 TOWN Catonsville		5yr 10mos 9days		LaPlata			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 Spring Grove State Hospital							
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
Francis		P.		Hamilton		October 11 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
Male	White	Single	6-1884	71 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farming		Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Hamilton				Catherine C. Dyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Unknown		Unknown		Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE						Approx. week	
(A) DUE TO Myocardial Infarction						Years	
ANTECEDENT CAUSE (B) DUE TO Coronary arteriosclerosis						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Generalized arteriosclerosis						Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Multiple pulmonary abscesses							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 7- , 19 53 to 10-11- , 19 55 that I last saw the deceased alive on 10-11- , 19 55, and that death occurred at 8:00A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Marie Frances Goodwood		Spring Grove State Hospital		10-11-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11-4-55		Catonsville 28, Maryland			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10-13-55		[Signature]		[Signature]		[Signature]	

MARGIN RESERVED FOR BINDING



9457

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>De Witt</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto Coun.</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>52 Carrollsville</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Becnyville</i>	TOWN <i>Becnyville</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove State Hospital</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (Type or Print) <i>Dora A. Hove</i>		4. DATE OF DEATH: (Month) <i>10</i> (Day) <i>30</i> (Year) <i>1955</i>	
5. SEX: <i>Fem.</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>	8. DATE OF BIRTH: <i>6-19-63</i>
9A. AGE last birthday <i>92</i> yrs.		9B. AGE last birthday (If under 1 year) (If under 24 hrs.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>BALTO. CO.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Solo moy Wolfgang</i>		14. MOTHER'S MAIDEN NAME: <i>Margart Harrett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.:	
17. INFORMANT & ADDRESS: <i>Mrs. Marie Mesley, 5214 Midwood Ave</i>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <i>450.0</i>			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11.17</i> , 1954, to <i>10.30</i> , 1955, that I last saw the deceased alive on <i>10.30</i> , 1955, and that death occurred at <i>11.15A</i> M, from the causes and on the date stated above.			
SIGNATURE <i>Rena Becker</i>		DATE SIGNED <i>10/30/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <i>11-2-55</i>		REGISTRAR'S SIGNATURE <i>Wm Cook</i>	
25. FUNERAL DIRECTOR ADDRESS <i>1217 St Paul St.</i>			

MARGIN RESERVE FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

09448

9458

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUB HILL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CUB HILL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9947 HARFORD ROAD</u>		STREET ADDRESS (If rural, give location) <u>9947 HARFORD ROAD</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>EMILY CLIFTON HARRISON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 20, 1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>SEPT. 26, 1888</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK SECRETARY - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAVINGS BANK</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY TUCKER HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>MARION JENIFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>FAMILY RECORDS</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>420.1 Coronary Occlusion Sudden</u>		
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		

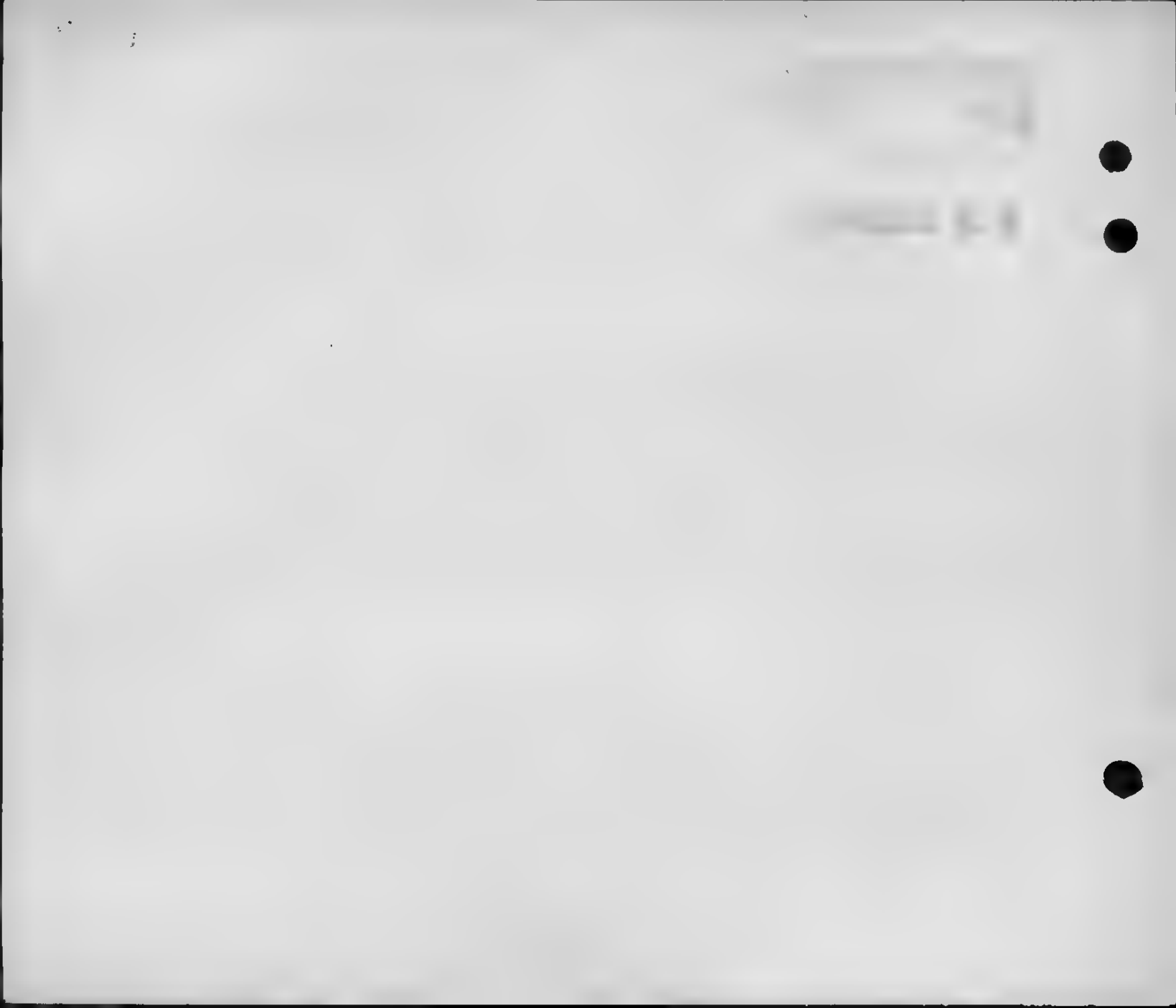
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		22. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐

SIGNATURE <u>Richard H. Womell M.D.</u>		ADDRESS <u>2501 East Rd. Towson, Md.</u>		DATE SIGNED <u>10/20/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>OCT. 24, 1955</u>	<u>PROSPECT HILL CEMETERY</u>	<u>TOWSON, MARYLAND</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>10/25/55</u>	<u>G. M. Bacon</u>	<u>John Brown</u>	<u>Towson, Md.</u>	

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The completed certificate is especially important. Physicians: please write the cause of death clearly and legibly.



9459

CERTIFICATE OF DEATH

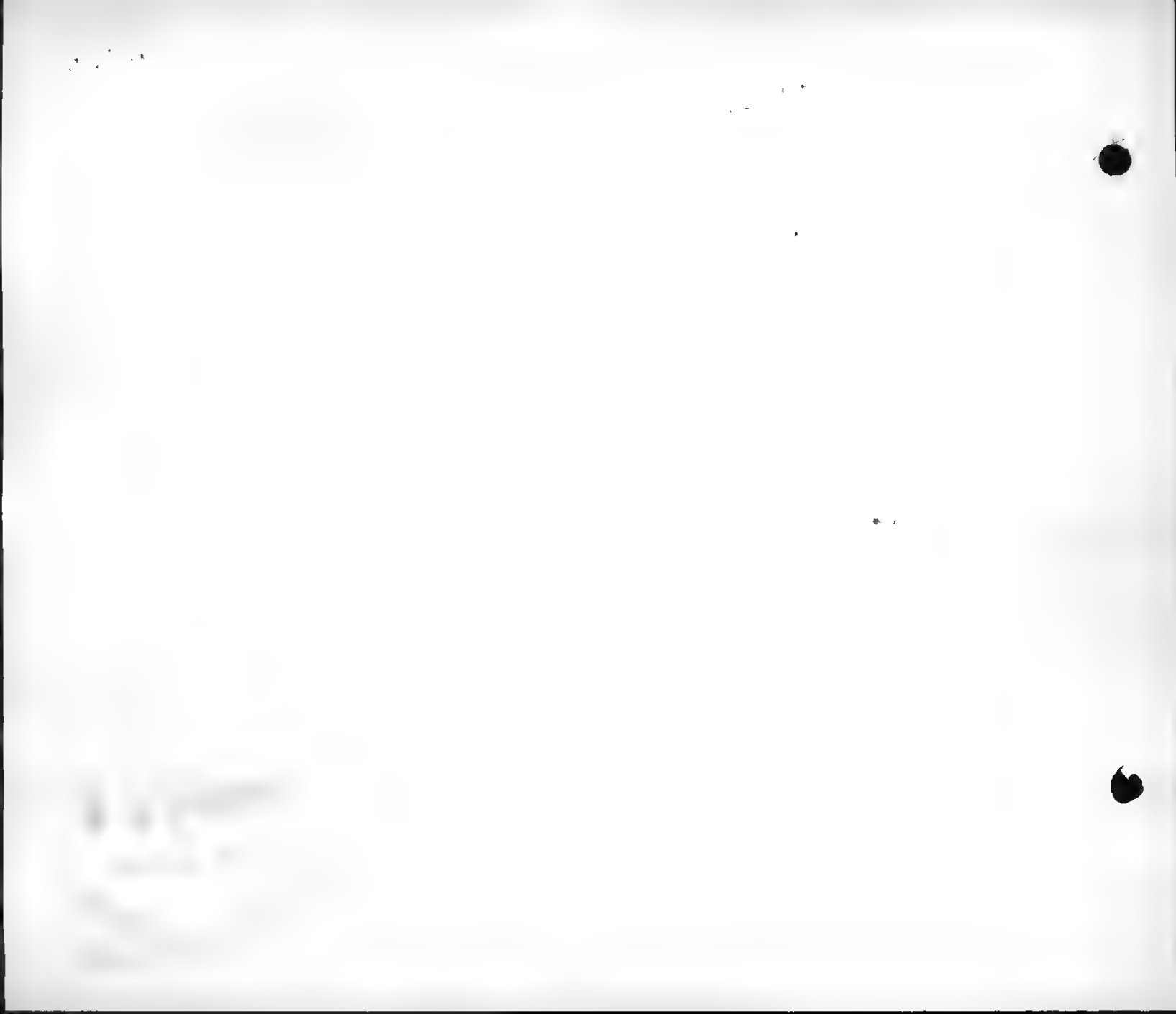
Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> OR <u>PIKESVILLE</u>	LENGTH OF STAY (In this place) <u>LIFE</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> OR <u>PIKESVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Old Court Rd</u>		STREET ADDRESS (If rural give location) <u>100 Old Court Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>NELLIE E. HAYES</u>		DATE OF DEATH: <u>10-27-1955</u>	
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>DEC 24 1870</u>
9. AGE last birthday <u>85</u> yrs.		10. UNDER 1 YEAR	11. UNDER 24 HRS.
12. MONTHS		13. DAYS	14. HOURS
15. MIN.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>LEWIS NELSON ELSE ROAD</u>		14. MOTHER'S MAIDEN NAME: <u>CAROLINE HOBENMY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>EMMA C. ELSE ROAD-100 Old Court</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Occlusion</u>		<u>1 month</u>	
ANTECEDENT CAUSE (B) <u>Due to</u> <u>Ar. & Sclerosis</u>		<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>		<u>5 yrs.</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21G. WHILE <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 195 <u>0</u> to <u>Oct. 27</u> , 195 <u>5</u> , that I last saw the deceased alive on <u>Oct. 26</u> , 195 <u>5</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>James H. Miller, M.D.</u>		DATE SIGNED <u>Oct. 27, 1955</u>	
ADDRESS <u>Pikesville, Md.</u>			
M.D. <u>Pikesville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. NAME OF CEMETERY OR CREMATORY <u>David Ridge</u>	
DATE THEREOF <u>10/29/55</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 29, 1955</u>		25. REGISTRAR'S SIGNATURE <u>Dorothy A. Newell</u>	
26. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>C-Pikesville, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09450

9380

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22		CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22	
TOWN DUNDALK 22		TOWN DUNDALK 22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1720 PINEWOOD RD.		STREET ADDRESS (If rural, give location) 1720 PINEWOOD RD.	
3. NAME OF DECEASED (Type or Print) CHARLOTTE		4. DATE OF DEATH (Month) 10- (Day) 10- (Year) 1955	
5. SEX F.		6. COLOR OR RACE W.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 10/2/1911	
9. AGE last birthday 44 yrs.		10. AGE last birthday 44 yrs.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME H. J. H. H. H.		14. MOTHER'S MAIDEN NAME H. H. H.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 172-10-400	
17. INFORMANT AND ADDRESS RICHARD K. HEFRIGHT - SAME ADDRESS		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) The Cerebro-Vascular Hemorrhage

(b) Hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH

48 hrs

20 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-12, 1955, to 10-10, 1955, that I last saw the deceased

alive on 10-9, 1955, and that death occurred at 10:55 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, RECEPTIONAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Oct 12-1955 William M. Kelly, Registrar

Funeral Home, 1000 N. Charles St., Baltimore, Md.

MAINTAINED RESERVED FOR BIDDING

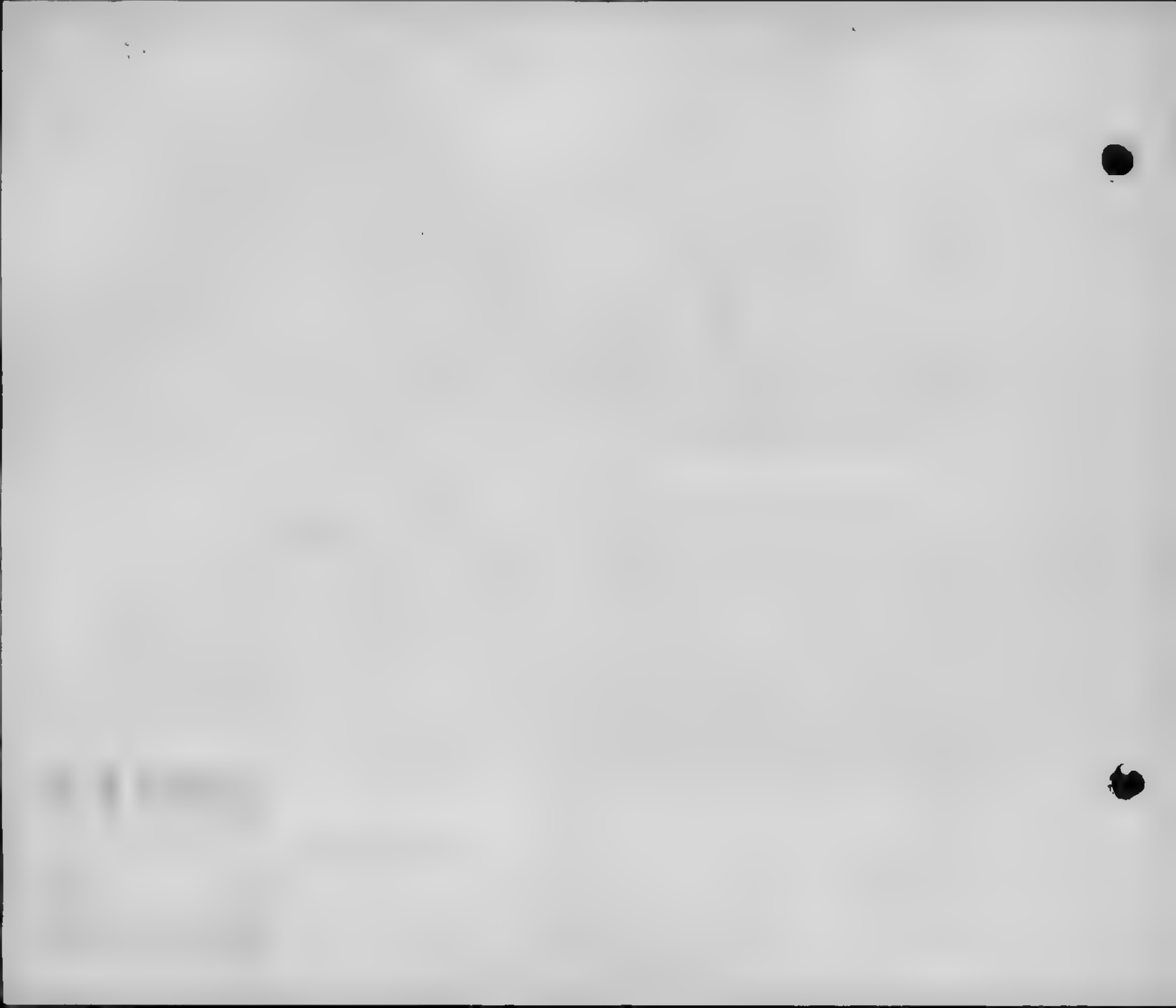
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

in O. p. 1007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

9391				09451			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
51 TOWN <u>Lundown</u>				TOWN <u>Shelburne</u>		<u>58 X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Palatka River</u>				STREET ADDRESS (If rural, give location)			
<u>Arundel Sand Co</u>				<u>1121 Armistead Pl</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>John William Heiser Sr</u>		<u>Oct 28</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>M</u>	<u>Sept 15 1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>unemployed Male</u>		<u>Coal Miner</u>		<u>Penn</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Heiser</u>				<u>Mary Burke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>205 05 6019</u>		<u>1121</u> <u>Mary Heiser Arundel Pl</u>	
15. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a)..... <u>Cornray Thrombosis</u>							
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF METETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Dr. McKieff</u>		<u>10-1-55</u>		<u>Shyrin</u>		<u>Arundel Pa</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF METETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-1-55</u>		<u>Shyrin</u>		<u>Arundel Pa</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct 29 53</u>		<u>Dr. McKieff</u>		<u>Arundel/Hulland</u>		<u>4107 Fulton Ave</u>	



1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09452

9460

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>24 Days</u>		Baltimore		<u>3214</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2016 Hunter Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JOHN</u> <u>W.</u> <u>HICKS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October</u> <u>28</u> <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>12-25-99</u>	
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Edward Hicks</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unk.</u>			
17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443x</u> IMMEDIATE CAUSE (A) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 YEARS</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 4</u>, 19<u>55</u>, to <u>Oct. 28</u>, 19<u>55</u>, and that death occurred at <u>11:00 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrift, Jr.</u>				DATE SIGNED <u>10-29-55</u>			
M.D. <u>VAH, FORT HOWARD, MARYLAND</u>				ADDRESS (Street, city, town, state) <u>217 E. Preston Street, Baltimore, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson L. Larker</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders Funeral Home</u>			
DATE <u>Oct 31</u>				ADDRESS <u>217 E. Preston Street, Baltimore, Md.</u>			



CERTIFICATE OF DEATH

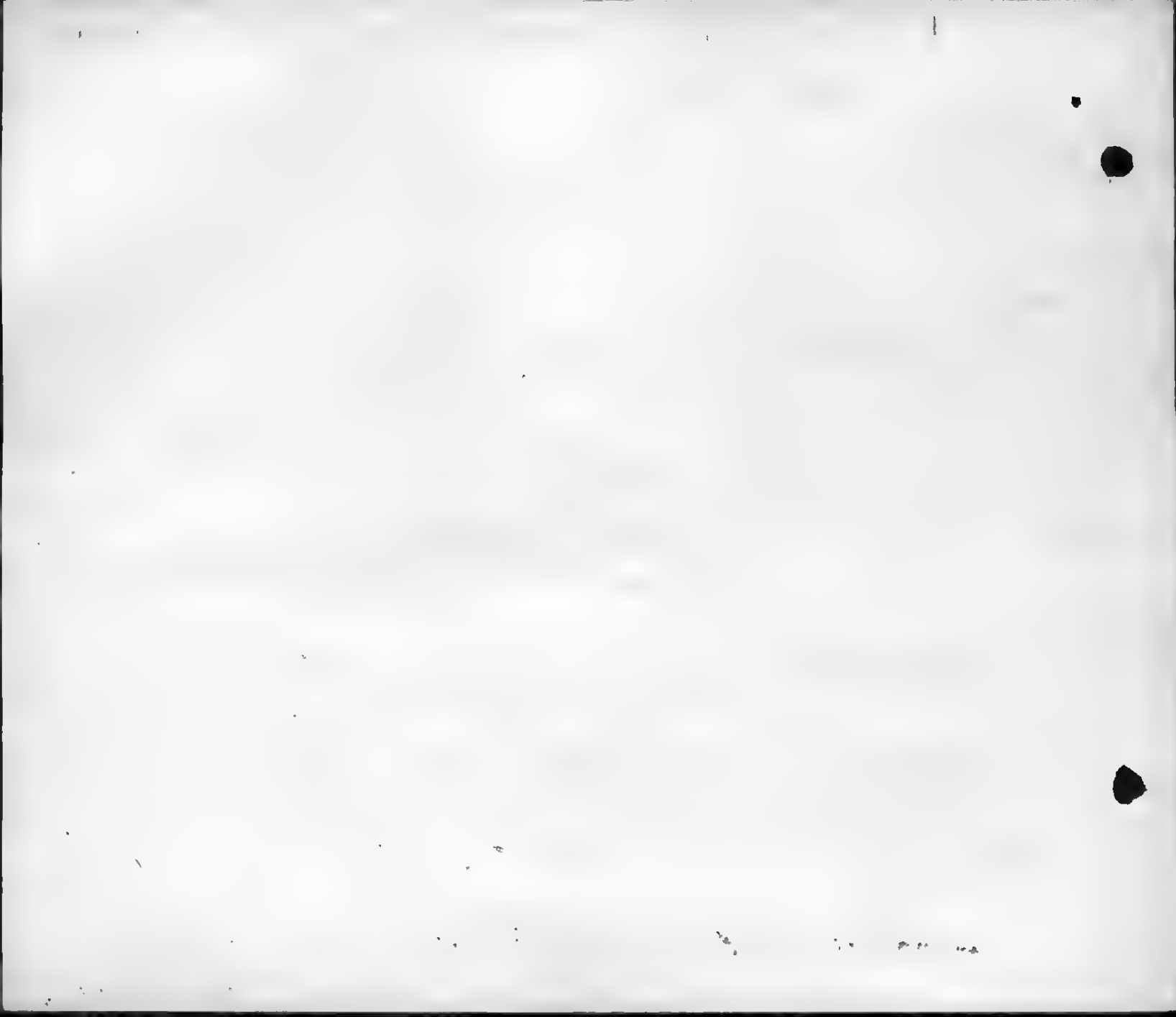
Reg. Dist. No.

9461

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>	LENGTH OF STAY (in this place) <u>368 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 29</u>	<u>38214</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		STREET ADDRESS (If rural give location) <u>511 Yale Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William J Hilbert</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>10 23 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/7/1892</u>
9. AGE last birthday: <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>16</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Inspector Gas & Elec. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Charles Hilbert</u>		14. MOTHER'S MAIDEN NAME: <u>Minnie Carl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-05-4380</u>	
17. INFORMANT & ADDRESS: <u>Mt. Wilson St. Hosp. Hospital Records, Mt. Wilson, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(A) <u>Carcinoma of the Lung</u>		<u>1 1/2 yrs.</u>	
IMMEDIATE CAUSE DUE TO			
(B) <u>Tuberculosis, pulmonary</u>		<u>2 yrs.</u>	
ANTECEDENT CAUSE (B): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/20, 1954</u> , to <u>10/23, 1955</u> , that I last saw the deceased alive on <u>10/23, 1955</u> , and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William Newman</u>		DATE SIGNED <u>10/23/55</u>	
ADDRESS <u>M.D. Mt. Wilson, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL, ETC.	DATE THEREOF <u>10/24/55</u>	NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>	LOCATION (City, town, or county) (State) <u>BALTO. M.D.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS <u>4101 EDMONDSON AVE</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ESSEX</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ESSEX</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>719 S MARLYN AVE</u>		STREET ADDRESS <u>719 S MARLYN AVE</u>	(If rural give location)
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>William</u>	(Middle) <u>Hildebrandt</u>	(Month) <u>OCT.</u>	(Day) <u>3</u>
(Type or Print)		(Year) <u>1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Oct. 23-1884</u>
		9. AGE last birthday: <u>70</u> yrs.	10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>IRON MOLDER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>RETH STEEL</u>	
11. BIRTHPLACE (State or foreign country): <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOHN HILDEBRANDT</u>		14. MOTHER'S MAIDEN NAME: <u>ANNA KOENIG</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>LENA E HILDEBRANDT</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <u>Cerebral apoplexy</u>		<u>Sudden</u>	
Antecedent causes (s) (b) <u>Arteriosclerotic Cardio-Vascular Disease</u>		<u>2 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At Work	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 2, 1955</u> , to <u>Oct 3, 1955</u> , that I last saw the deceased alive on <u>Oct 3, 1955</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>M. D. 855-2 Phila Rd Balto 6</u>		DATE SIGNED <u>10/3/55</u>	
(Degree or title)		ADDRESS	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>PARKWOOD</u>	
DATE THEREOF <u>10/6/55</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-5-55</u>		REGISTRAR'S SIGNATURE <u>John B Connelly</u>	
		24. FUNERAL DIRECTOR ADDRESS <u>Essex 21 md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9453

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PARK HALL</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catoesville</u>		LENGTH OF STAY (in this place) <u>1950 to 10/11/55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Park Hall 18x-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 SPRING GROVE STATE HOSP</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MINNIE WOOD HILL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>10 11 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-2-1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NURSE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>RICHARD H. WOOD</u>				14. MOTHER'S MAIDEN NAME: <u>JEMIMA WOOD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>William</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
58100 IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4, 1955</u> to <u>10/12</u> , 19 <u>55</u> that I last saw the deceased alive on <u>July 4, 1955</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>		ADDRESS <u>M.D. Spring Grove H. Hosp.</u>		DATE SIGNED <u>10/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Andrews</u>		LOCATION (City, town, or county) (State) <u>Leonardtown</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/2/55</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		24. FUNERAL DIRECTOR <u>J.C. Mattingly</u>		ADDRESS <u>Leonardtown</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.



Item 21 Film G188 11-9-55

CERTIFICATE OF DEATH

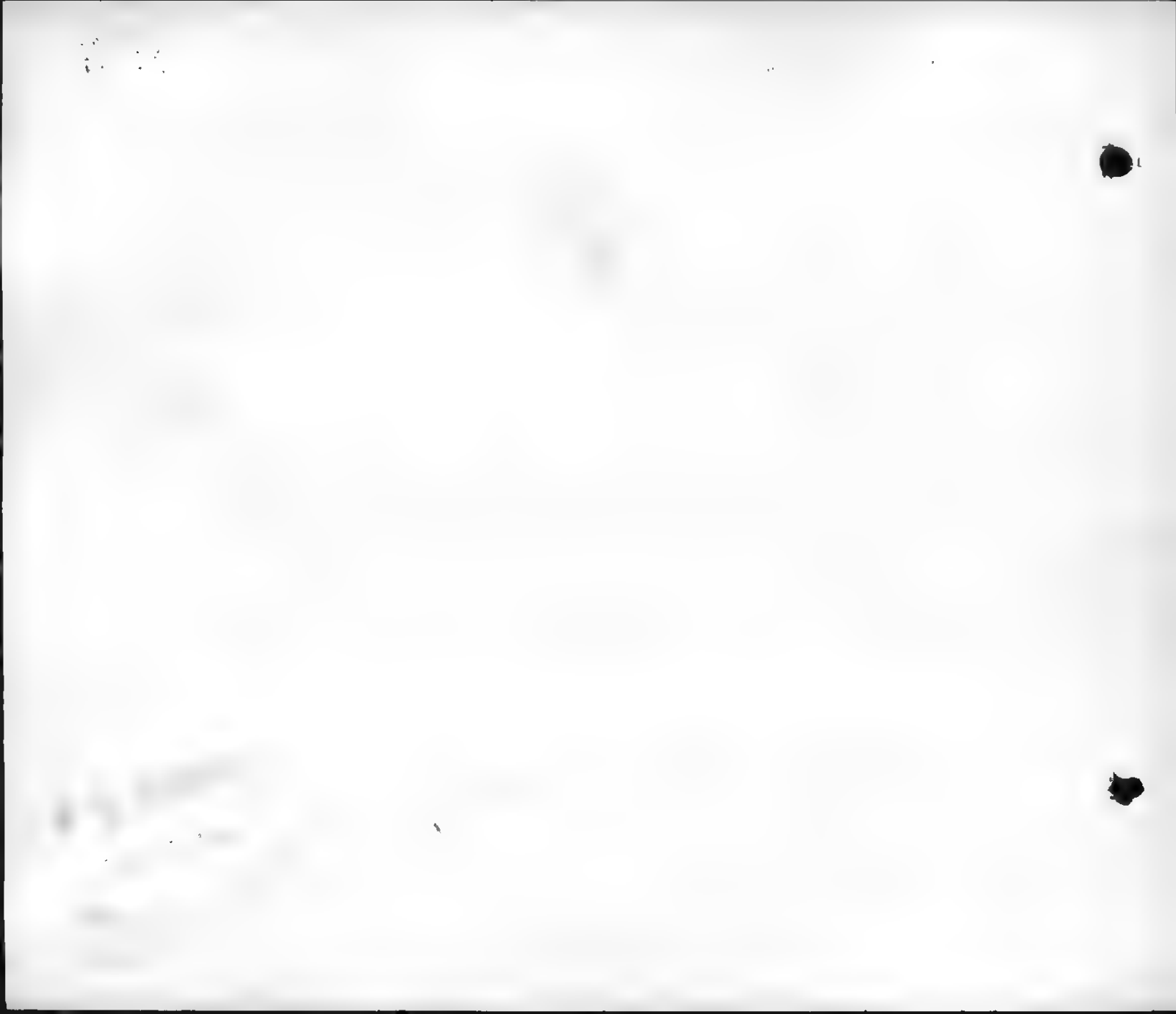
Reg. Dist. No. 38

9464

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Ruxton</u>				STREET ADDRESS (If rural give location)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Maple Avenue</u>				<u>Maple Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>JULIA ANN HOOK</u>				OF DEATH: <u>OCT. 29 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>June 10, 1867</u>	
9. AGE last birthday <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Eli Scott Bond</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Ann Rowe</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Family Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>				<u>Sudden</u>			
ANTECEDENT CAUSE (S) <u>Fractured Left Hip</u>				<u>7 Days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>General Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Coronary Arteriosclerosis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Bedroom</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Balto. Md.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 22 55 8P.M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>Fell while walking around bed.</u>			
22. I hereby certify that I attended the deceased from <u>Nov 1, 1955</u> , to <u>Oct. 28, 1955</u> that I last saw the deceased alive on <u>October 18, 1955</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Charles F. Donnell</u>				DATE SIGNED <u>10/21/55</u>			
ADDRESS <u>M.D. 7501 York Rd #4md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

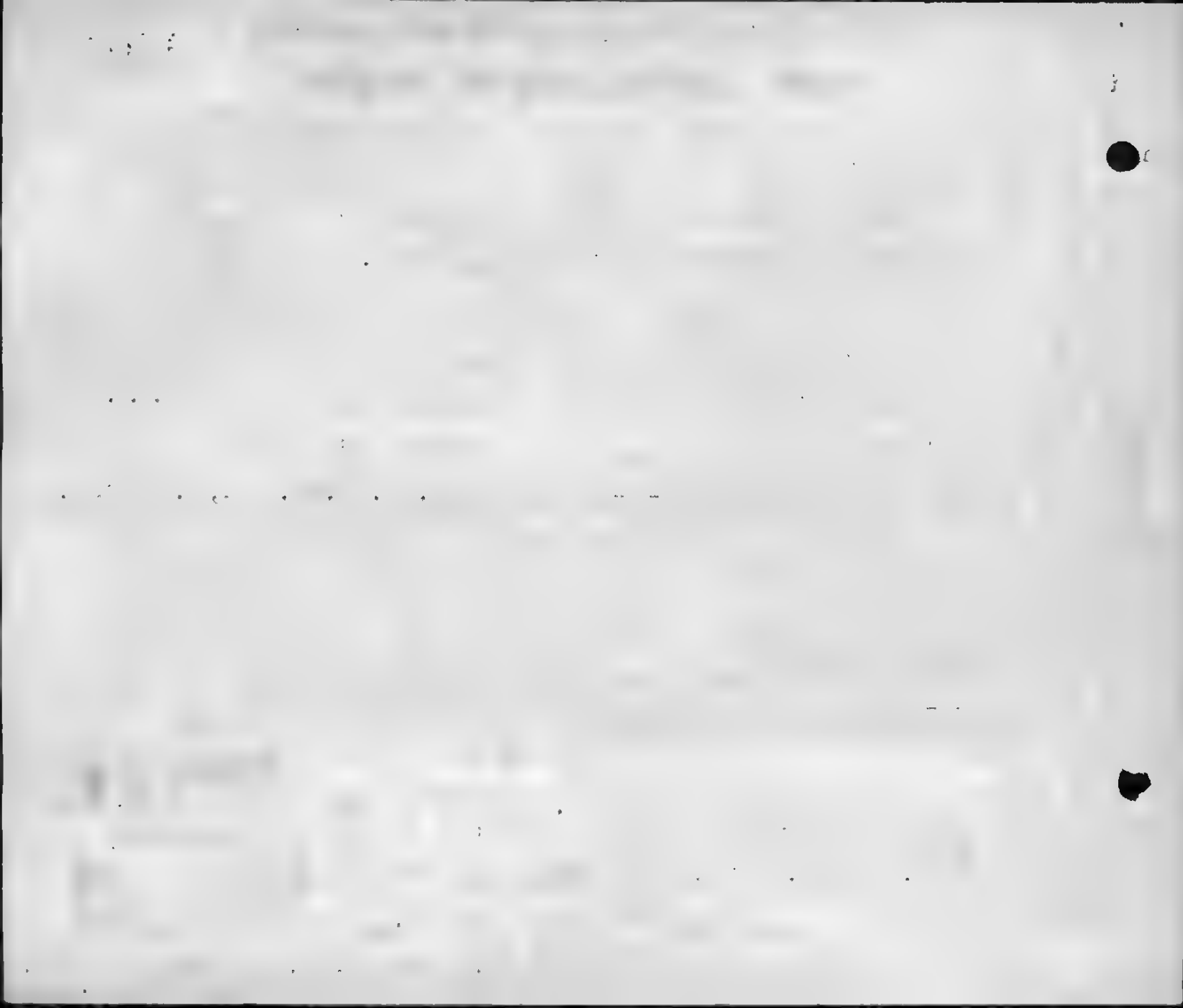
9465

CERTIFICATE OF DEATH

09457

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>39 Days</u>		TOWN <u>Baltimore</u>		<u>3601-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1837 E. Lombard Street</u>			
3. NAME OF DECEASED (Type or Print) <u>MIKE</u> (First) <u>HORTON</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/8/96</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tug boat worker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harry Horton</u>				14. MOTHER'S MAIDEN NAME <u>Catherine MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>			16. SOCIAL SECURITY NO. <u>218-07-2447</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>1-4X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA OF RECTUM</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7-8-54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Exploratory Laparotomy & sigmoid colostomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 15, 1955, to October 24, 1955, and that death occurred at 10:35 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey, M.D. Chief, Medical Service VAH, FORT HOWARD, MARYLAND</u>				DATE SIGNED <u>10-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>OCT 28 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>James L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>			
DATE <u>Oct. 28, 1955</u>				ADDRESS <u>6009 Harford Rd., Balto. Md.</u>			



9466

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN		TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorensen Nursing Home 7912 Ruxton Rd.		STREET ADDRESS (If rural give location) 424 Whitridge Ave.	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) ANNA	(Middle) MAY FISHER	(Last) HULL	DATE OF DEATH: Oct. 4, 19 55
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed	8. DATE OF BIRTH: Aug. 26, 1875
9. AGE last birthday: 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rtd Practical Nurse - self Emp.	11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Lucien Fisher	

14. MOTHER'S MAIDEN NAME: Celia A. Parker		15. INFORMANT & ADDRESS: Mr. Harry W. Rohr - 4019 Roland Ave.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no		17. SOCIAL SECURITY NO.: no	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) Pulmonary Embolus.		6 hours.
ANTECEDENT CAUSE (B) Malignancy Intestine.		Several years.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) metastasis of malignancy.		Gradual.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15, 1955, to Oct. 4, 1955, that I last saw the deceased alive on Oct. 2, 1955, and that death occurred at 6 P. M. from the causes and on the date stated above.

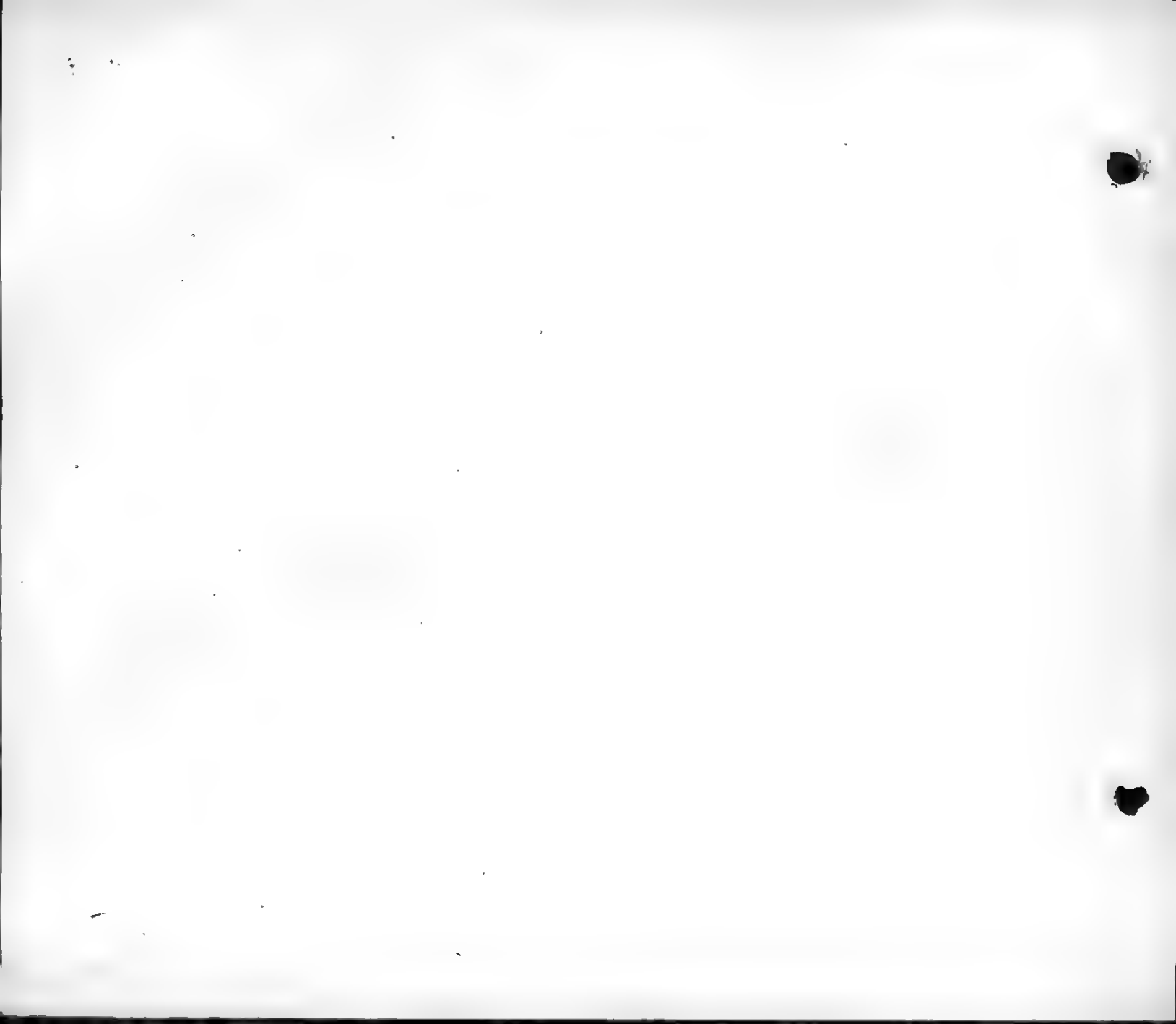
SIGNATURE: J. M. Graham Marston. ADDRESS: 516 Cambridge St. DATE SIGNED: Oct. 5, 1955.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10/5/55	Central Cem.	Millbury, Mass.

DATE REC'D BY LOCAL REGISTRAR: 10/5/55	REGISTRAR'S SIGNATURE: [Signature]	24. FUNERAL DIRECTOR: [Signature]	ADDRESS: [Address]
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9467

CERTIFICATE OF DEATH

09459

Reg. Dist. No. 44

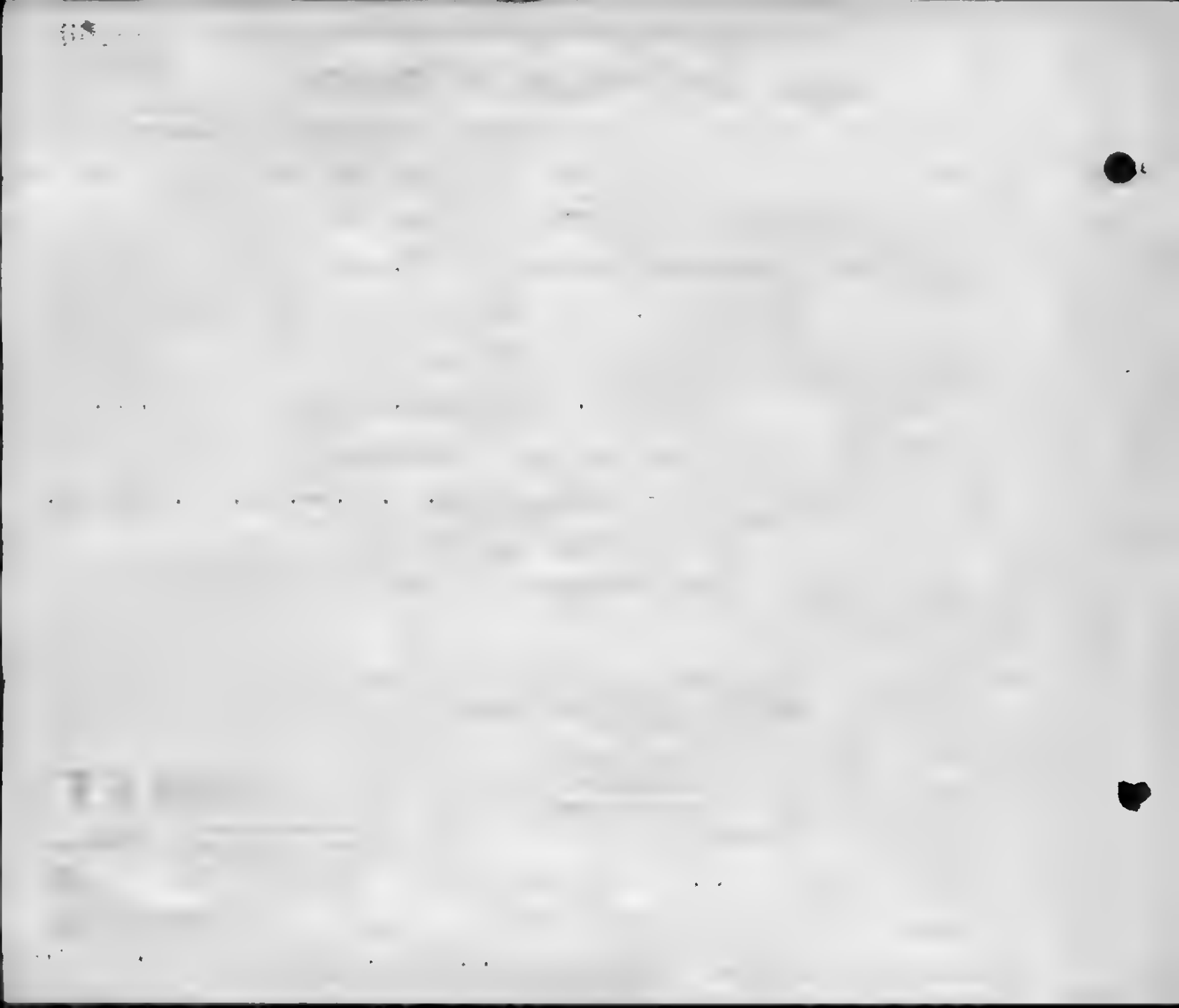
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>2012</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>150 Days</u>		TOWN <u>Newcomb</u>		<u>2012</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O. Box</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>OTIS B. HUNT</u>				<u>October 29 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>2-1-94</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Woodworker</u>		<u>Woodwork Co.</u>		<u>Royal Oak, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard Hunt</u>				<u>Rose Leonard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WW-I</u>				<u>146-10-6642</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>ACUTE NEPHROSIS RIGHT KIDNEY</u>						<u>UNKNOWN</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>NODULAR ENLARGEMENT OF PROSTATE</u>						<u>UNKNOWN</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>7/18/55</u>		<u>NEPHRECTOMY FOR TUBERCULOSIS</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u> 19 <u>55</u> , to <u>October 29</u> 19 <u>55</u> , that he was the deceased and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/2/55</u>		<u>Bristol Cemetery</u>		<u>Bristol, Pennsylvania</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Ransom L. Farber</u>		<u>G.L. Schwab</u>		<u>2101 Frederick Ave., Balto., Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



9459

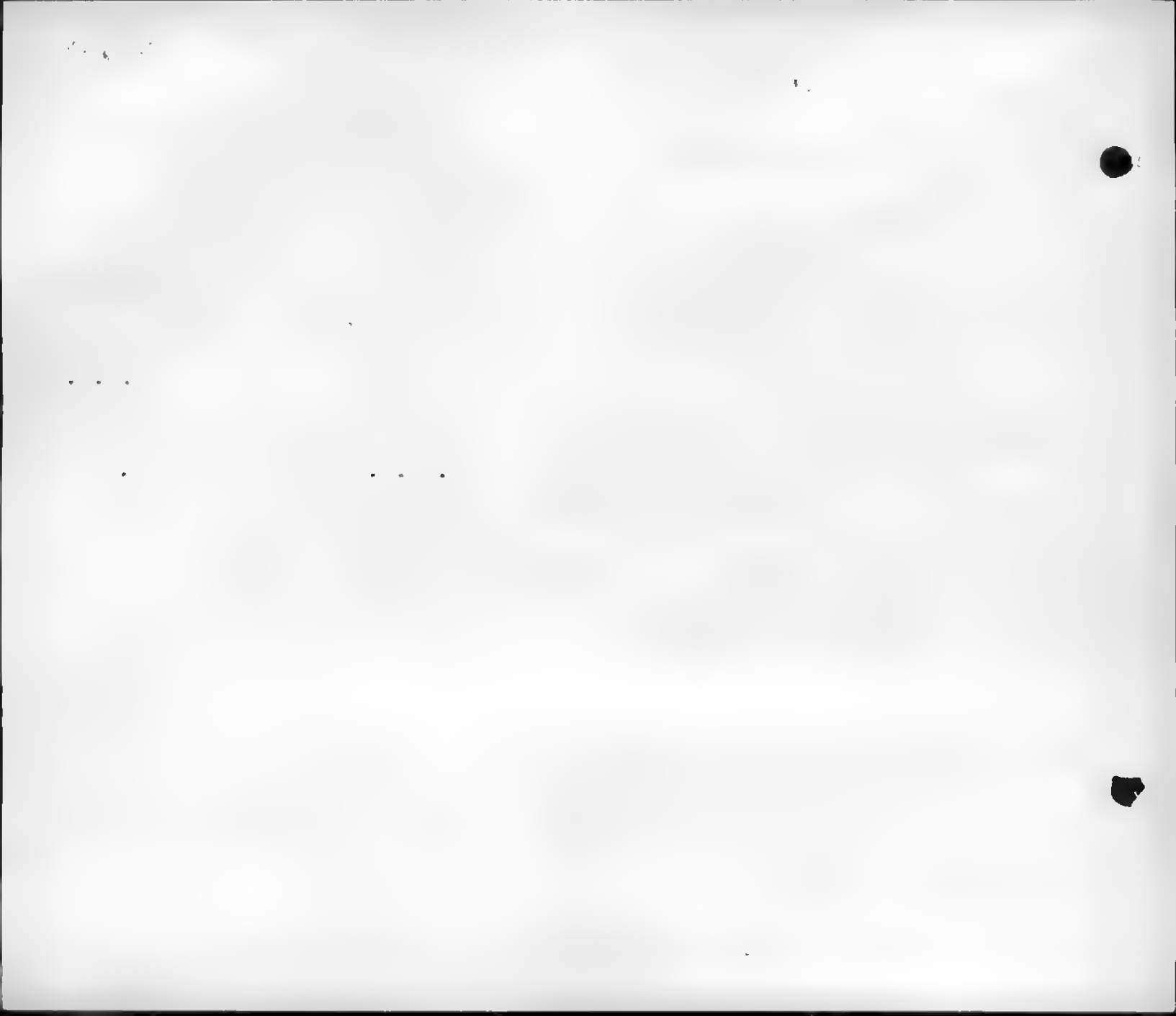
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Granite</u>				TOWN <u>Granite</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>Herndon Road</u>			
3. NAME OF DECEASED: (Type or Print) <u>Clemmie Mozell Irvin</u>				4. DATE OF DEATH: <u>October 3, 1955</u>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>October 2, 1877</u>	
						9. AGE last birthday IF UNDER 1 YEAR: <u>78</u> yrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Georgia</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Singelton Branson</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. O.B. Smith, Herndon Rd. Granite, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				<u>1 day</u>			
ANTECEDENT CAUSE (B) <u>Hypertensive C.V. Disease -</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE 1, 1955</u> , to <u>OCT 3, 1955</u> , that I last saw the deceased alive on <u>OCT 3, 1955</u> , and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. Wheeler</u>				ADDRESS <u>M. D. 3601 Clipman Rd 2nd</u>		DATE SIGNED <u>OCT 10 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 6, 1955</u>		<u>Mountain View</u>		<u>Hackett, Arkansas</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-55</u>		<u>[Signature]</u>		<u>Ellsworth Armacost</u>		<u>4600 Liberty Hgt</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

09462

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *1*

9470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <i>Balto.</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <i>MD.</i> COUNTY <i>BALTO.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>GLEN ARM</i>		<i>30 yrs</i>		TOWN <i>GLEN ARM</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>GLEN ARM, MD</i>				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>GLENIOUS C. JACKSON</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>10 8 1953</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>April 18, 1896</i>	9. AGE last birthday <i>59</i> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CONTRACTORS</i>		11. BIRTHPLACE (State or foreign country) <i>VA.</i>	
13. FATHER'S NAME <i>CATHER JACKSON</i>		14. MOTHER'S MAIDEN NAME <i>ESTHER JACKSON</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218053216</i>		17. INFORMANT AND ADDRESS <i>ANNA JACKSON - GLEN ARM, MD</i>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *March 9, 1934*, to *Oct. 8, 1953*, that I last saw the deceasedalive on *Oct 8, 1953*, and that death occurred at *4 P.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4 9 1 4

24



1



MARYLAND

09463
STATE DEPARTMENT OF HEALTH

9471

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2831 Summitt Avenue		STREET ADDRESS 2831 Summitt Avenue	
3. NAME OF DECEASED (First) Mrs. Alice (Middle) E. (Last) Jager		4. DATE OF DEATH (Month) October (Day) 19th (Year) 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Oct. 10, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME E. Eckhardt		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME Frances Higgins		14. INFORMANT AND ADDRESS Mr. George Claybaugh, 2610 Evergreen Ave #14	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
434.3 Immediate cause (a).....		Pneumonia	
Antecedent cause(s) (b).....		Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19. DATE OF OPERATION 1/20	
19a. DATE OF OPERATION 1/20		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 1954 to 1955, that I last saw the deceased alive on Oct 17, 1955, and that death occurred at 2:00 p.m. from the causes and on the date stated above.	
SIGNATURE		DATE SIGNED 10/20/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Oct. 22, 1955	
NAME OF CEMETERY OR CREMATORY Moreland Mem Park		LOCATION (City, town, or county) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. 10/20/55		24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14	

MARGIN RESERVED FOR INDEXING

Dr. Kasik

9005 Harford Road

NO 5 8692

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9472

CERTIFICATE OF DEATH

Reg. Dist. No.

09464

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lutherville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>				STREET ADDRESS (If rural give location) <u>603 Murdock Rd.</u>			
3. NAME OF DECEASED: (First) <u>JOHN</u> (Middle) <u>COVINGTON</u> (Last) <u>JETT</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 19, 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 1, 1865</u>	9. AGE last birthday: <u>90</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>19</u>		IF UNDER 24 HRS.: Hours <u>55</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>rtd Gen. Agt.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Fire Insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Robert E. Jett</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah A. Covington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>-</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service): <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. Ewell K. Jett - 4546 N. Charles St.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Brain aneurysm</u>						6 days	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>April, 1955</u> , to <u>Oct 19, 1955</u> , that I last saw the deceased alive on <u>October 18, 1955</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. Allan Linn</u>		ADDRESS <u>M. D. 4408 Rockaway Blvd</u>		DATE SIGNED <u>Oct. 19, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-29-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons</u>		ADDRESS <u>Balto 17, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

11-5-48

11-5-48

9473

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <i>Lutherville</i>		3 yrs.		TOWN <i>500 Bosley Avenue 55</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>College Manor</i>				STREET ADDRESS (If rural give location) <i>TOWSON</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
MINNIE JOHNSON				October 28, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
			5, 1966	89 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Salamanca, N.Y.		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William T. Fish				Mary Jeanette R			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
(If Yes, give year or dates of service)							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE				(A) Generalized arteriosclerosis			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2 I hereby certify that I attended the deceased from 8/2, 1955, to 10/28, 1955, that I last saw the deceased alive on 9/16, 1955, and that death occurred at 1:25 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Madison P. J. ...		1700 Penna. Ave. Towson		M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Oct. 29, 1955		Hunt Co. F.		11, "	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct. 29, 1955		Madison C. Gray		John Burnie Sono			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10.11.17

11.11.17

12.11.17

13.11.17

14.11.17

MARYLAND STATE DEPARTMENT OF HEALTH

09466

9474

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Ba 1 t o</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Ba 1 t o</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ba 1 t o 14</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ba 1 t o 14</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3136 Acton Rd</u>		STREET ADDRESS (If rural, give location) <u>3136 Acton Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Hermine</u>	<u>F</u>	<u>Joiner</u>	
6. SEX <u>Female</u>	8. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 15-1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Custom Service</u>	11. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u>	9. AGE last birthday <u>46 yrs.</u>
13. FATHER'S NAME <u>Joseph P. Pfeiffer</u>	14. MOTHER'S MAIDEN NAME <u>Hermine Stumpf</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>215-01-1428</u>	17. INFORMANT AND ADDRESS <u>Mr. Varnon W. Joiner - 3136 Acton Rd</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

44-X
Immediate cause

(a)

Ruptured aortic aneurysm

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertensive heart disease

INTERVAL BETWEEN ONSET AND DEATH

4 hours67 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, or office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1954, to Oct 5, 1955, that I last saw the deceasedalive on Oct 5, 1955, and that death occurred at 12:30 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 10/8/55 Parkwood Cem Ba 1 t o md

Oct 8-1955 Monrovia Reframiner Local Funeral Home 7401 Belair Rd.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13311 North Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9475

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09467

Reg. Dist.

No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Catonsville		5yr. 3mos. 23days		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural, give location) 2631 Park Heights Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Morris Kalichman				October 5, 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed		8. DATE OF BIRTH: 11-10-1894	
9. AGE last birthday: 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		11. BIRTHPLACE (State or foreign country): Russia		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME: Jacob Kalichman				14. MOTHER'S MAIDEN NAME: Mary Madas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
15. Unknown		Unknown		Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... Acute Coronary Thrombosis							
DUE TO							
Antecedent cause(s) (b)..... Coronary Arteriosclerosis							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)..... Generalized arteriosclerosis							
DUE TO							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		1010 Leads on		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-5-55	
Geo. J. M. Kieffer				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, OR REMOVAL (Specify): Burial		DATE THEREOF 10-7-55		NAME OF CEMETERY OR CREMATORY Mt. Carmel		LOCATION (city, town, or county) Balto (State) MD	
DATE REC'D BY LOCAL REG. 10-7-55		REGISTRAR'S SIGNATURE Wm. H. H. H. H. H.		24. FUNERAL DIRECTOR Jack Lewis		ADDRESS 2100 Cutaw Pl	



9478

CERTIFICATE OF DEATH

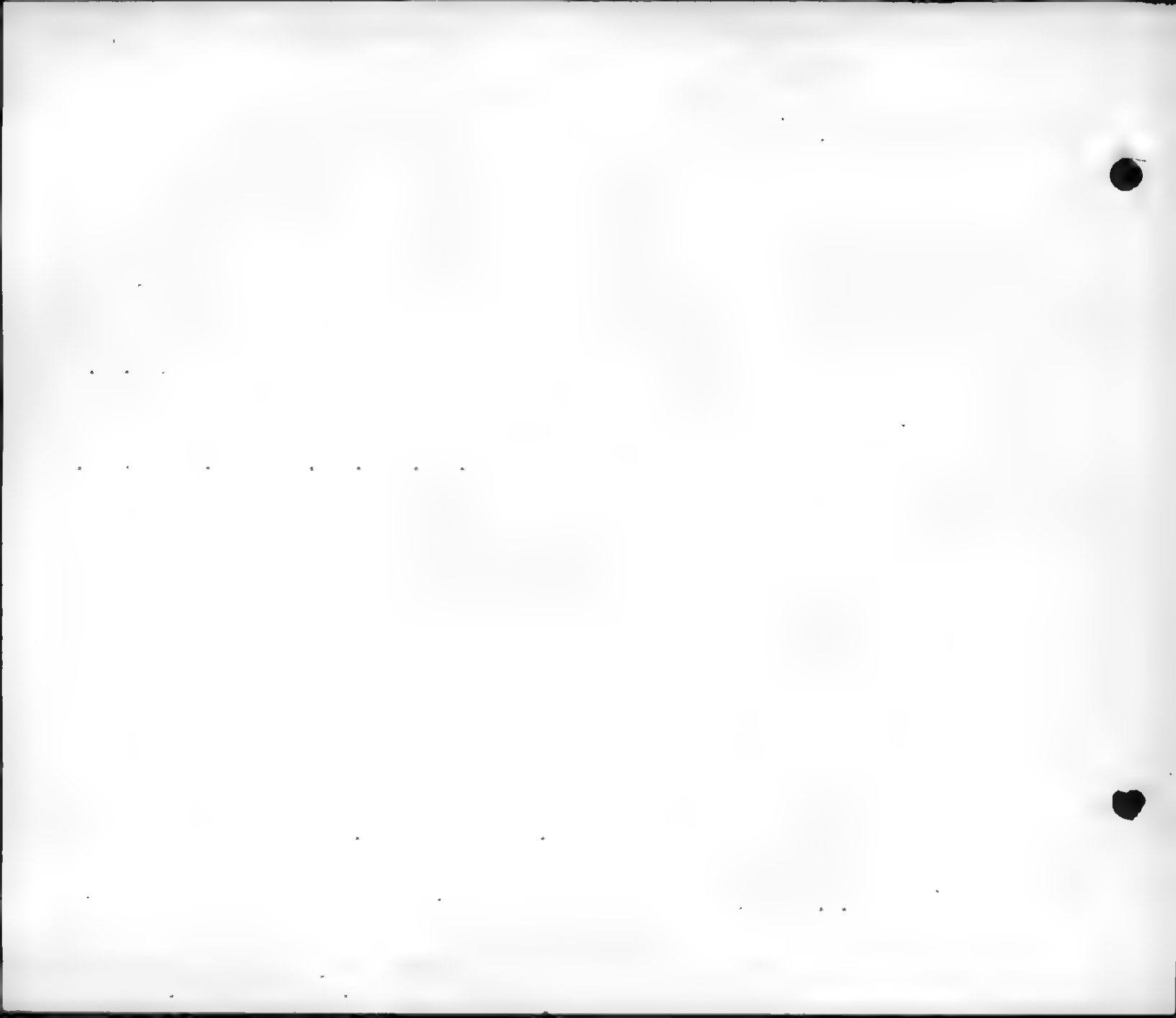
Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u> MARYLAND			STATE <u>MARYLAND</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN <u>FORT HOWARD</u>			TOWN <u>BALTIMORE</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>			STREET ADDRESS (If rural give location) <u>4318 PIMLICO ROAD,</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH		
<u>JACOB (NM) KATZ</u>			<u>OCTOBER 20, 1955</u>		
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>5/15/95</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>READY TO WEAR</u>		11. BIRTHPLACE (State or foreign country): <u>RUSSIA</u>	
13. FATHER'S NAME: <u>PHILLIP W. KATZ</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>			16. SOCIAL SECURITY NO. <u>215-10-8186</u>		
17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>			<u>1 HOUR</u>		
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, MYOCARDIAL INFARCTION, OLD</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(262X)</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>			<u>UNKNOWN</u>		
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>AUG. 1, 1955</u> , to <u>OCT. 20, 1955</u> , and that death occurred at <u>3:35</u> M, from the causes and on the date stated above.					
SIGNATURE <u>Francis Dickey, M.D.</u>		ADDRESS <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10-20-55</u>	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>10-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>JACK LEWIS, INC. FUNERAL HOME 2100 EUTAW PL., BALTIMORE, MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09463

9477

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Whittemarsh, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Whittemarsh, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ebenezer + Red Lion Rds.</u>		STREET ADDRESS (If rural, give location) <u>Ebenezer + Red Lion Rds.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Viola</u> (Middle) <u>Olle</u> (Last) <u>Keithley</u>	4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 4, 1882</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>73</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Cecil County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. George</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Chennoweth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Charles S. Keithley</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause(a) Coronary Infarction
(b) Hypertensive Cardiovascular Dis.
(c)

INTERVAL BETWEEN ONSET AND DEATH

5 min

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Benign Carcinoma Stomach 3 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/3, 1947 to Oct. 18, 1955, that I last saw the deceased(alive on 10/17, 1955) and that death occurred at 8:45 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Oct. 23, 1955</u>	<u>Baker's</u>	<u>Aberdeen, Md.</u>	
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>10/27/55</u>	<u>W. A. H. Brown</u>	<u>Kassahn Funeral Home</u>	<u>7401 Belair Rd</u>	

MARGIN RESERVE FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

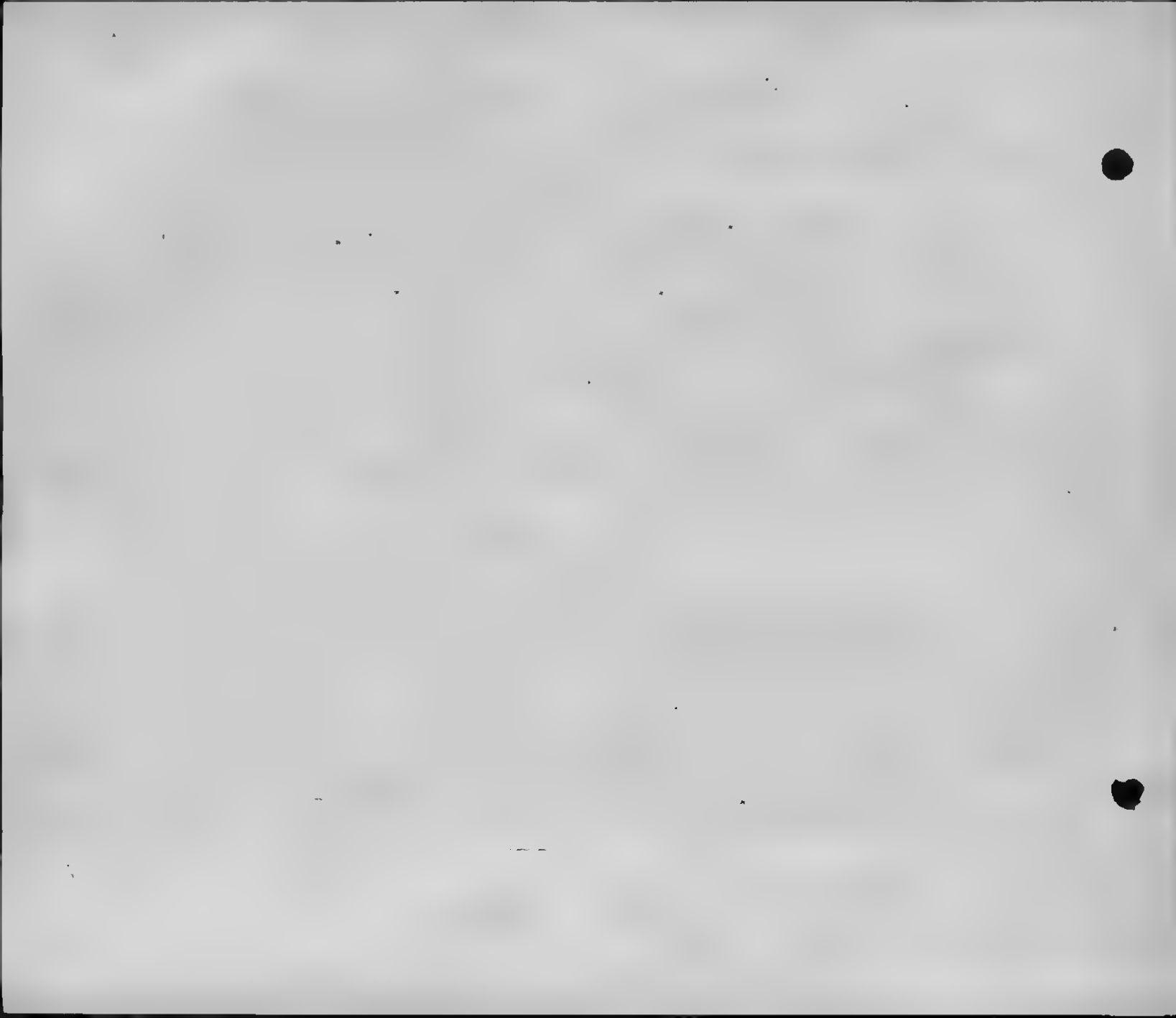
Reg. Dist.

No. 1.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(a) Craniocerebral injury DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street	21c. (City or town) (County) (State) Baltimore Maryland	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Speeding auto - out of control	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE William W. Walters		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.		DATE SIGNED 10/14/55
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 10/18/1955	(NAME OF CEMETERY OR CREMATORY) Holy Redeemer	LOCATION (City, town, or county) Baltimore	(State) Md
DATE REC'D BY LOCAL REG. 10-53	REGISTRAR'S SIGNATURE H. H. Walters	24. FUNERAL DIRECTOR H. H. Walters		ADDRESS Pratt & Stricker Sts

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information you give is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

9479

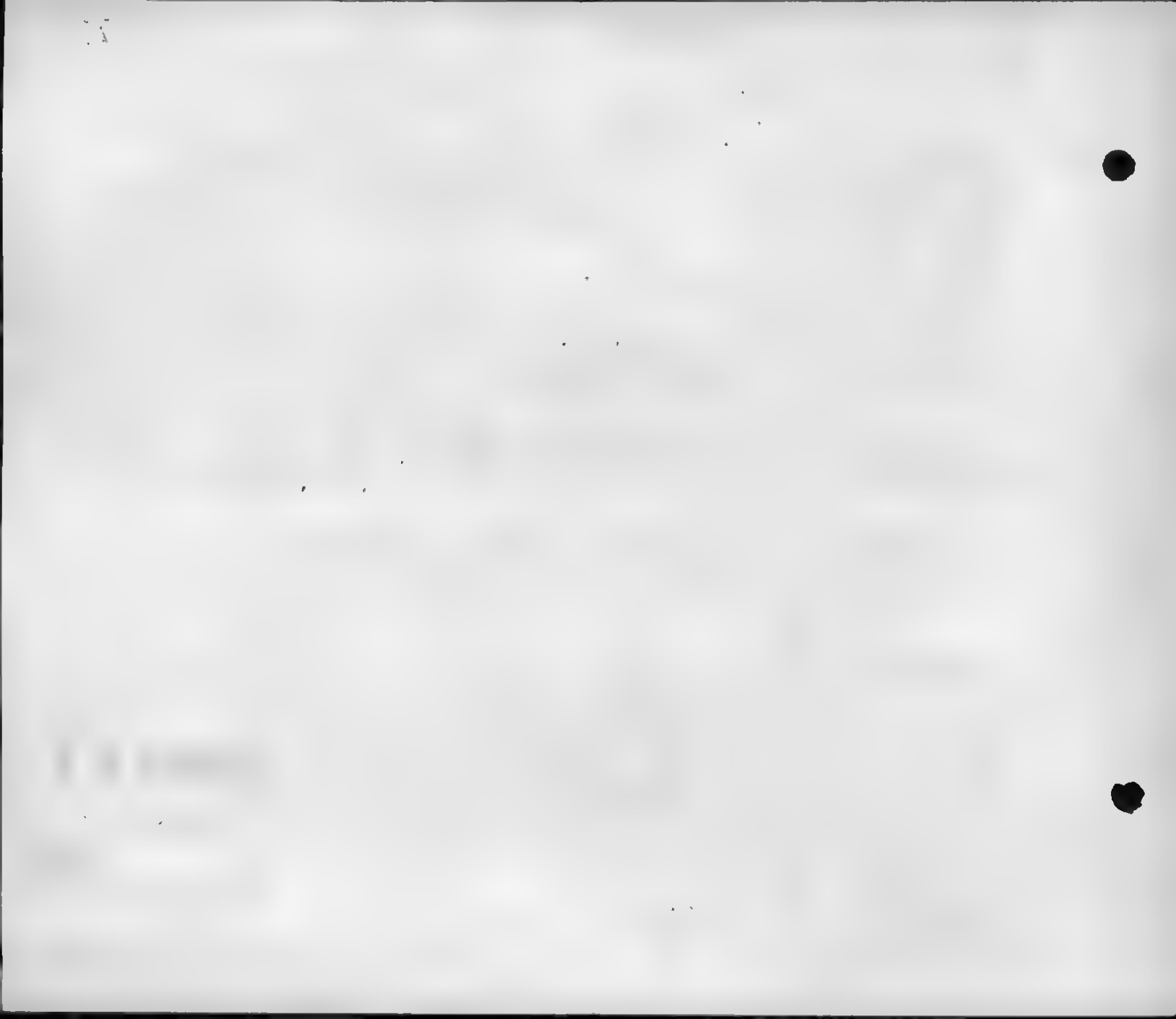
09471

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1001 N. T. St.</u>		STREET ADDRESS (If rural, give location) <u>1001 N. T. St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Frank</u>		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 2, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Freight</u>	9. AGE last birthday <u>66</u> yrs. If under 1 year Months Days Hours Min
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mont R.</u>		14. MOTHER'S MAIDEN NAME <u>Doris R.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Baltimore County Health Board, Towson</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> Immediate cause (a) <u>Arteriosclerosis</u> Antecedent cause(s) (b) <u>giving rise to the above cause stating the underlying cause last</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>			<u>2 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-15-55</u> , 19 <u>55</u> , to <u>10-19-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-17-55</u> , 19 <u>55</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>[Address]</u> DATE SIGNED <u>10-19-55</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE <u>10-21-55</u>		LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>10-21-55</u>		24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>[Address]</u>	



MARYLAND

09472
STATE DEPARTMENT OF HEALTH

9480

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2200 OLD FREDERICK RD.		STREET ADDRESS (If rural, give location) 2200 OLD FREDERICK RD.	
3. NAME OF DECEASED (Type or Print)	(First) CARL	(Middle) HENRY	(Last) KINZEL
4. DATE OF DEATH	(Month) OCT.	(Day) 3	(Year) 1955
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH April 15, 1886
9. AGE last birthday 69 yrs.		10. If under 1 year Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME CHRISTIAN KINZEL		14. MOTHER'S MAIDEN NAME MINNIE BOCKMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Carl H. Kinzel - 2200 Old Fred. Rd.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause BRONCHIECTASIS BRONCHITIS.		2.5 yrs.
(b) Antecedent cause(s) HEPATITIS WITH JAUNDICE.....		1 MO
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION 10	19b. MAJOR FINDINGS OF OPERATION 1	
21. ACCIDENT SUICIDE HOMICIDE (Specify) 1	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) 10	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan-6, 1953** to **Oct-3, 1955**, that I last saw the deceased alive on **Oct 1 - 1955**, and that death occurred at **6:45 A.M.**, from the causes and on the date stated above.

SIGNATURE J. Lloyd Johnson	(Degree or title) MD	ADDRESS Catonville, Md.	DATE SIGNED 10/5/55
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE 10-6-55	NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE REC'D BY LOCAL REG. 10/5/55	REGISTRAR'S SIGNATURE V.E. Harry	24. FUNERAL DIRECTOR Forley Funeral Home, Catonville, Md.	ADDRESS

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09473

9481

CERTIFICATE OF DEATH

Reg. Dist. No. 3c

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ridgewood Manor		STREET ADDRESS 3497 Milford Ave. (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Henry Klauti		4. DATE OF DEATH Oct. 11, 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH 8/19/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Ludwig Cab. Mak.	9. AGE last birthday 80 yrs. If under 1 year If under 24 hrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. 212-51-5098-A	
17. INFORMANT Hannah Klauti		3497 Milford Ave. Balto.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

Immediate cause

(a)

Infection of eye

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b)

Arteriosclerosis (General)

(c)

Phlebitis of leg (left)

INTERVAL BETWEEN
ONSET AND DEATH

3 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐
(STATE)

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **8-11**, 19**55**, to **10-11**, 19**55**, that I last saw the deceased
alive on **10-11**, 19**55**, and that death occurred at **10-11** a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 10/14/55	NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	LOCATION (City, town, or county) Woodlawn Md.	(State)
DATE REC'D BY LOCAL REG. 10-13-55	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Harry A. Amacost	ADDRESS 424 Ridgewood Ave.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9482

CERTIFICATE OF DEATH

Reg. Dist. No.

09474

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	LENGTH OF STAY (in this place) <u>6/11/54 - 10/29/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto. City</u>	<u>34-14</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hospital</u>		STREET ADDRESS (If rural give location) <u>2235 Hilton Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FREDERICK JUSTICE KOCHLER</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>10 29 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>2/1/1871</u>
9. AGE last birthday: <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>WILLIAM KOCHLER</u>	
14. MOTHER'S MAIDEN NAME: <u>MARY MILLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS: <u>LULA KOCHLER - 2235 Hilton St.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>450.0 CARDIAC FAILURE</u>			<u>10/28/55</u>
ANTECEDENT CAUSE (B) <u>ADVANCED ARTERIOSCLEROSIS</u>			<u>to</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<u>10/29/55</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>July 4, 1953</u> , to <u>10/29, 1955</u> , that I last saw the deceased alive on <u>10/29, 1955</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Sue Wachsler</u>		DATE SIGNED <u>10/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-1-55</u>	NAME OF CEMETERY OR CREMATORY <u>Western</u>
LOCATION (City, town, or county) (State) <u>Balto, Maryland</u>		24. FUNERAL DIRECTOR ADDRESS <u>Cooper 12125 Paul St</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/31/55</u>		REGISTRAR'S SIGNATURE <u>G. H. K. W.</u>	



100

100

100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09477

9434

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 TOWN Catonsville		7 days		Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 Spring Grove State Hospital				842 Wildwood Parkway			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Harry P. Lambros				October 20, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR, Months	IF UNDER 24 HRS., Days	IF UNDER 24 HRS., Hours
Male	White	Married	1-10-1887	68 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Restaurant cook					Greece		USA
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Peter Lambros				Diana Kaludis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS.		
Unknown			Unknown		Records Spring Grove State Hospital		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.1 Coronary thrombosis						7 days	
ANTECEDENT CAUSE (B) Arteriosclerotic cardiovascular disease						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Residual hemiplegia							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic arthritis							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-14- , 19 55 , to 10-20- , 19 55 that I last saw the deceased alive on 10-20- , 19 55 , and that death occurred at 11 A. M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
S. Wachler		Spring Grove State Hospital		10-20-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/22/55		Greek Orthodox Cem.		Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
October 22, 1955		R.W.		Am. J. Tichenor & Sons - Baetz, 17 Md			



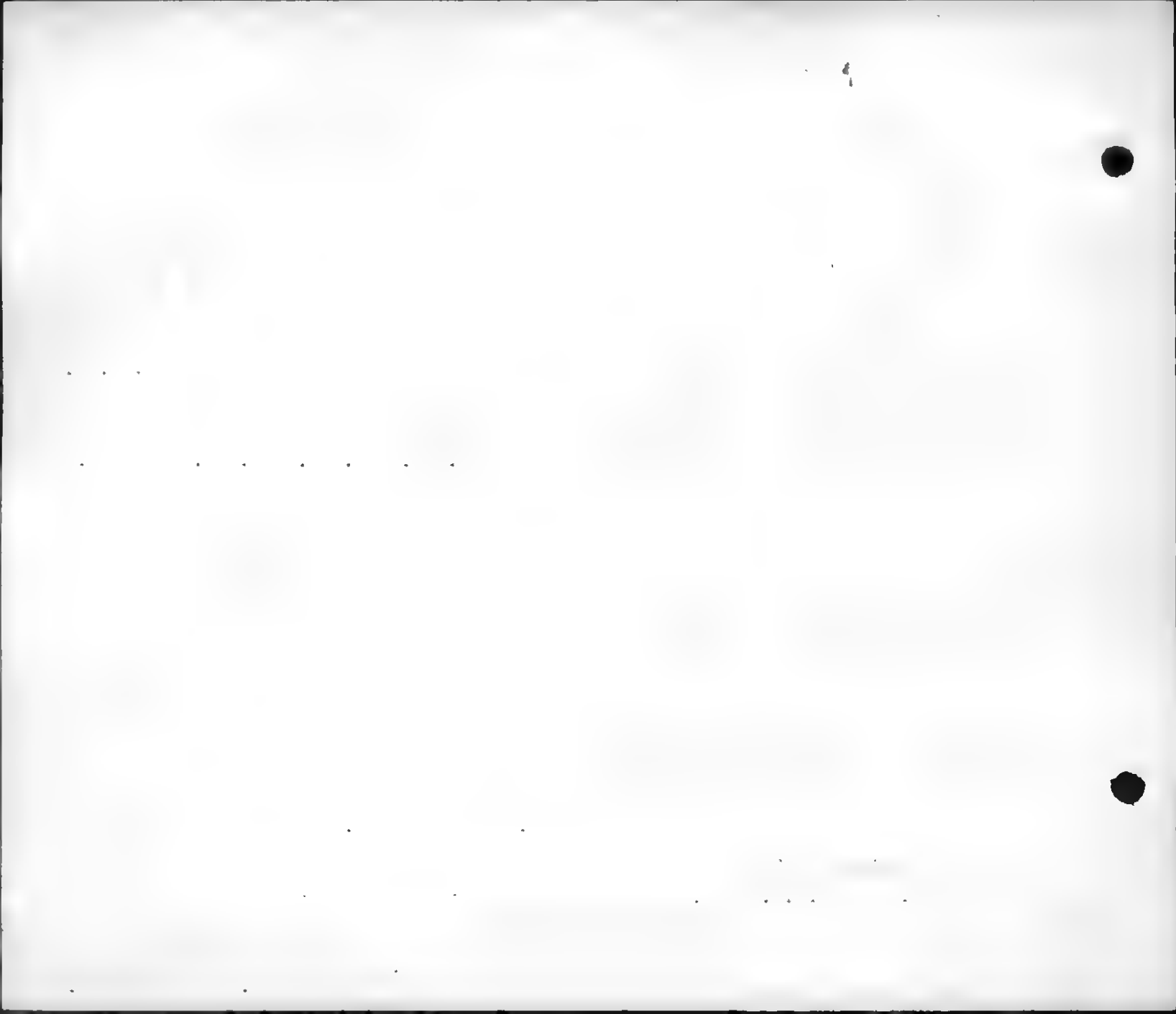
9485 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 16 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 5302 ETHELBERG AVENUE			
3. NAME OF DECEASED: (First) EDGAR (Middle) (NMI) (Last) LA TART				4. DATE (Month) (Day) (Year) OF DEATH OCTOBER 9 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH: 7/9/89	9. AGE last birthday 66 yrs.	IF UNDER 1 YR. Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY: CATERERS		11. BIRTHPLACE (State or foreign country): CLAYTON, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JOHN LA TART				14. MOTHER'S MAIDEN NAME: LETITIA MC CARTHY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) VV I		16. SOCIAL SECURITY NO. 109-05-2165		17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) ADENOCARCINOMA OF RECTUM WITH METASTASES						9 MONTHS	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SEPT. 23 1955 , to OCT. 9, 1955 , and that death occurred at 5:00PM , from the causes and on the date stated above.							
SIGNATURE FRANCIS G. DICKEY, M.D. Chief, Medical Service		ADDRESS VAH, FORT HOWARD, MARYLAND		DATE SIGNED 10-10-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 10/12/55		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 10-12-55		REGISTRAR'S SIGNATURE DMR		24. FUNERAL DIRECTOR VERNON C. LEMMON FUNERAL HOME		ADDRESS 4611 PARK HEIGHTS AVE., BALTIMORE, MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Balto MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this place)
TOWN Catonsville

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS Wayne Nursing Home
Smithwood & Summit Aves.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Baltimore 2401-4

STREET
ADDRESS (If rural give location)
4507 Springdale Ave.

3. NAME OF DECEASED:

(First) (Middle) (Last)
CARRIE W. LEVY

4. DATE (Month) (Day) (Year)
OF DEATH: Oct 24 1955

5. SEX:

6. COLOR OR
RACE:
white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): widowed

8. DATE OF BIRTH:
July 18, 1872

9. AGE last birthday: 83 yrs. 19 55
Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if retired: housewife

10b. KIND OF BUSINESS OR
INDUSTRY:
at home

11. BIRTHPLACE (State or foreign country):
Md.

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Samuel Flaunlacher

14. MOTHER'S MAIDEN NAME:

Sarah Wornitz

15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) NO

16. SOCIAL SECURITY No.:
none

17. INFORMANT & ADDRESS:

Mrs. Irvin Gordon - 4507 Springdale Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

334X

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b)

DUE TO

(c)

Hebiplegic Right.
Generalized Arteriosclerosis

Interval Between
Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1953, 1955, to 24 Oct. 1955, that I last saw the deceased
alive on 22 Oct. 1955, and that death occurred at 1:30 AM, from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. M. Smith M.D. 1707 Edmund Ave. Catonsville 28 Md. 24 Oct. 55

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial 10/26/55 Balto. Hebrew Cem. Balto., Md.
A. W. Hedright M. J. Turner & Sons - Balto 17 Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

9487

1. PLACE OF DEATH:

COUNTY

BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN

Essex

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

361 Townsend Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD.

COUNTY

BALTO.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Essex

(If rural, give location)

STREET

ADDRESS

619 FRANKLYN Ave.

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

Chamney A. Lewis

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

10 - 15

19

55

5. SEX:

M

6. COLOR OR

RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

MARRIED

8. DATE OF BIRTH:

NOV 15, 1884

9. AGE last birthday:

70

yrs.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life,
or if retired, state occupation)

MAINTENANCE

10b. KIND OF BUSINESS OR
INDUSTRY:

GLEN-MARTIN

11. BIRTHPLACE (State or foreign country):

Pa.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

John Lewis

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

216-07-4556

17. INFORMANT & ADDRESS:

Estelle Lewis (Same)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Metastatic carcinoma, intra-abdominal and pulmonary

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b)

DUE TO

Origin unknown

(c)

INTERVAL BETWEEN
ONSET AND DEATH

1 yr

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not while
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 10, 1955, to Oct 15, 1955, that I last saw the deceased
alive on Oct 14, 1955, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10/17/55

H.W. Hedrick

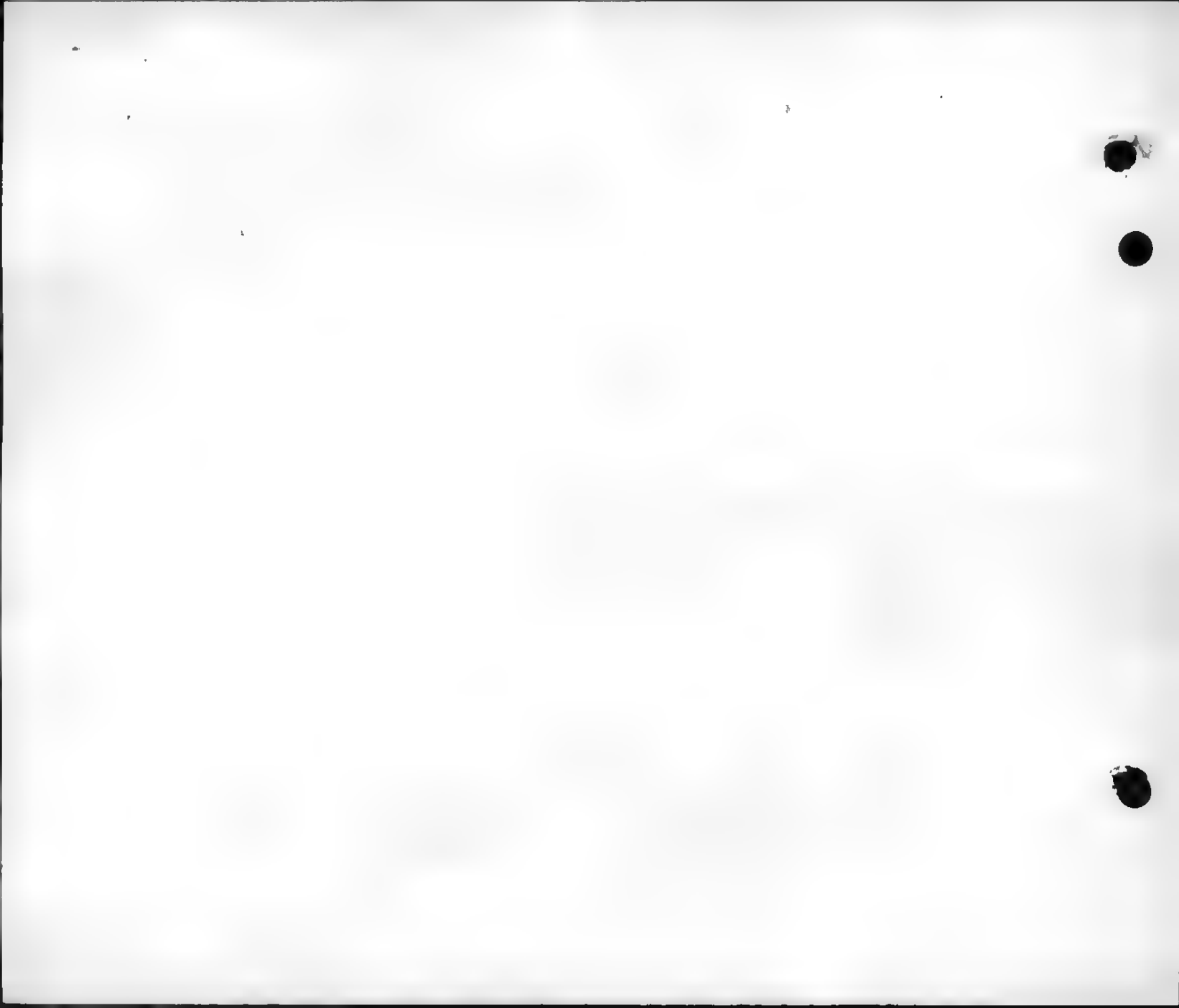
J. Gordon Connolly

Essex, Md.

MARGIN RESERVE FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

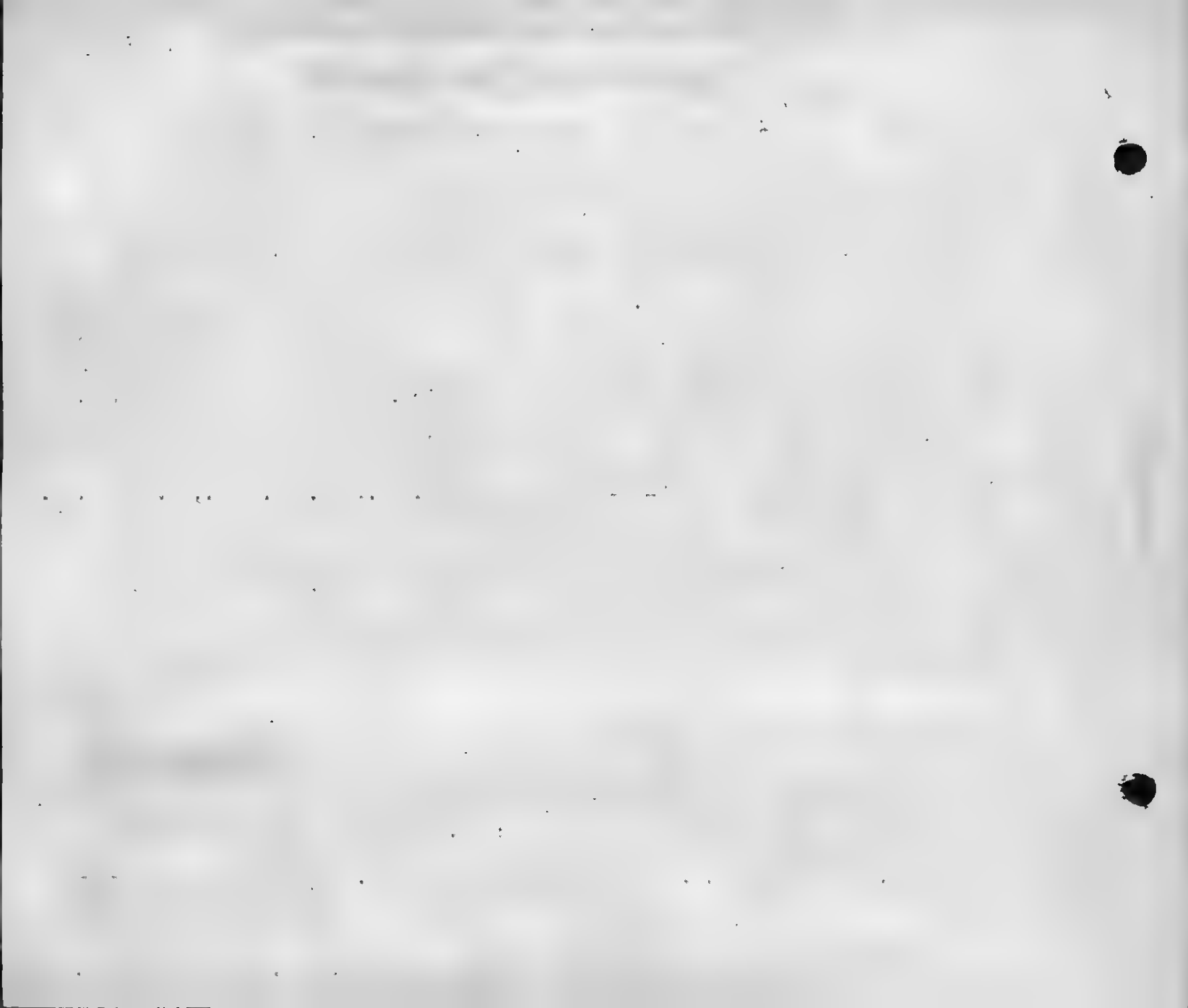
9488

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
VETERANS Administration Hospital		839 Glade Court		VETERANS Administration Hospital		839 Glade Court	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u> (Middle) <u>C.</u> (Last) <u>LEWIS</u>				(Month) <u>October</u> (Day) <u>23</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>5/26/98</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Clerk</u>		<u>Civil Service</u>		<u>Mount Airy, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas Lewis</u>				<u>Eva O'Neill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WW I</u>		<u>217-12-0937</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF LEFT LUNG</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) <u>TUBERCULOSIS OF APEX OF LOWER LOBE, LEFT LUNG</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>002X</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 4</u> , 19 <u>55</u> , to <u>October 23</u> 19 <u>55</u> , the cause of death was <u>CARCINOMA OF LEFT LUNG</u> and the death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegriest, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH FORT HOWARD, MARYLAND</u> DATE SIGNED <u>10-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>OCT 26 1955</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 25, 1955</u>		<u>Samuel L. Fisher</u>		<u>Wm. Cook-Blight, Inc.</u>		<u>6009 Harford Rd. Baltimore 14, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

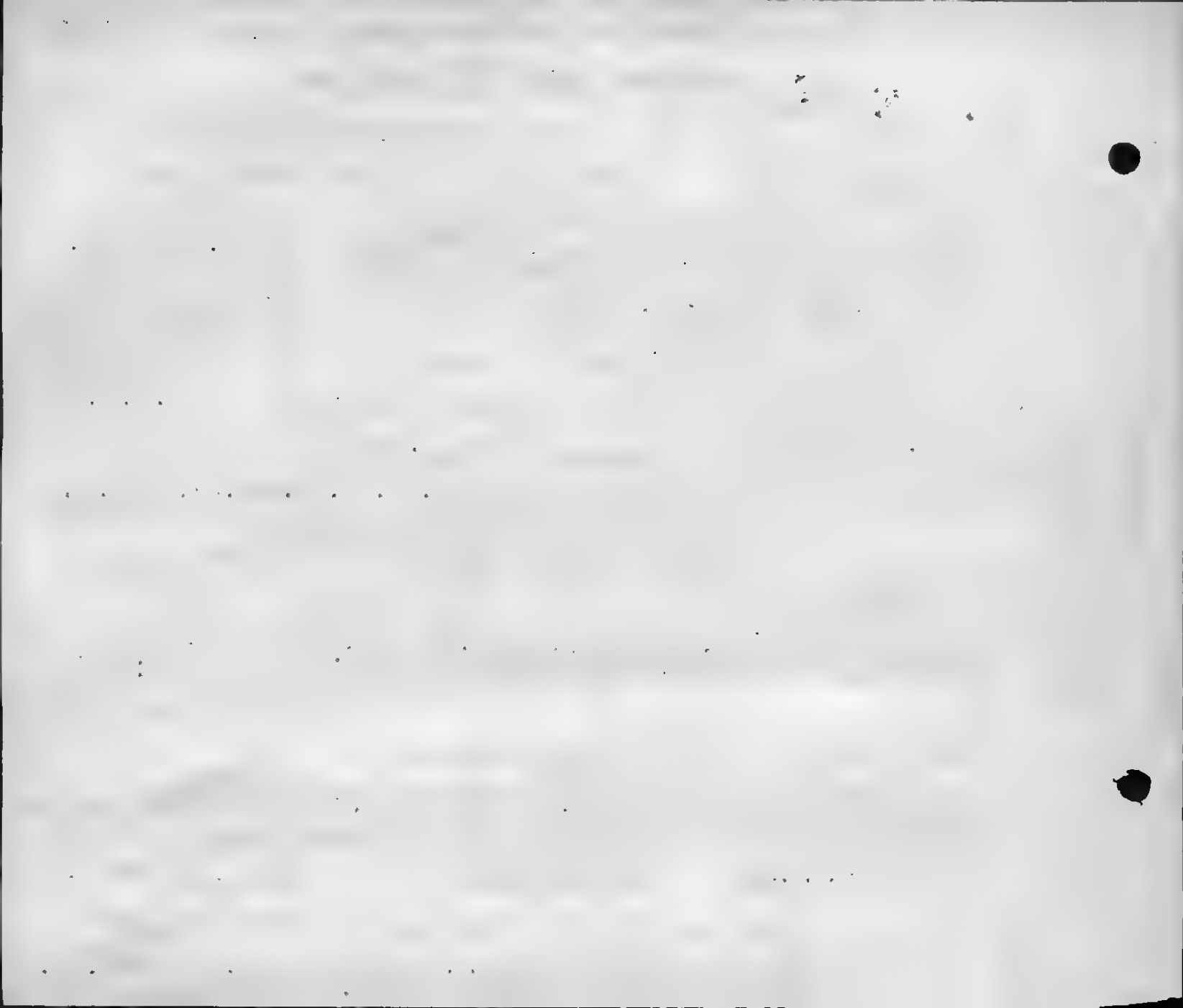
10555

CERTIFICATE OF DEATH

9439

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>9 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Formerly of 1100 Calvert St. No permanent address</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES M. LOUGHBOROUGH</u>				<u>October 31 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>9/17/76</u>	<u>79</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Reporter</u>		<u>News Paper</u>		<u>Little Rock, Arkansas</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>James M. Loughborough</u>				14. MOTHER'S MAIDEN NAME <u>Mary W. Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>Unknown</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1. Tuberculosis, chronic, Pulmonary Moderately Advanced, inactive. (2) Decubitus ulcer, lt. foot & ankle</u>						1. <u>Unknown</u>	
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work					
22. I hereby certify that I attended the deceased from <u>Oct. 22, 1955</u> , to <u>Oct. 31, 1955</u> , and that death occurred at <u>9:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Milton Ginsberg</u>				ADDRESS (Street, city, town, state) <u>FORT HOWARD, MARYLAND</u>			
DATE <u>Nov. 7, 1955</u>				DATE SIGNED <u>11-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/4/55</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov. 7, 1955</u>		<u>Manson L. Farley</u>		<u>Wm. J. Tickner & Sons, Inc.</u>		<u>North Penna. Ave. Baltimore, Md.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 38

9490

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Brooklandville,		20 yrs.		X TOWN Brooklandville,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Valley Road				STREET ADDRESS Valley Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Harry Percy Lucas				Oct. 16, 19 55			
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed		8. DATE OF BIRTH: March 8, 1876	
				9. AGE last birthday: 79 yrs.		10. IF UNDER 1 YEAR: Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President-General Utilities &				10b. KIND OF BUSINESS OR INDUSTRY: Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Harry Pike Lucas				14. MOTHER'S MAIDEN NAME: Annabelle Merryman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: Md. Mr. Edgar M. Lucas Valley Rd. Brooklandville,			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Interval BETWEEN ONSET AND DEATH							
Immediate cause (a)..... Carcinomatosis							
DUE TO							
Antecedent cause(s) (b)..... Carcinoma of the Colon							
DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Pneumonia							
2 days							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
OF INJURY		M.					
22. I hereby certify that I attended the deceased from May 4, 19.55., to Oct. 15, 19.55., that I last saw the deceased alive on Oct. 15, 19.55., and that death occurred at 3:30 A.m., from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE) ADDRESS		DATE SIGNED	
Waverly S. Green, Jr. M.D.				Pikesville 8, Balto. Co., Md.		Oct. 16, 1955	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 18, 1955		Druid Ridge		Pikesville, Md.	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
		Mabel Gray		John O. Mitchell & Sons 1900 Eutaw Place			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UVA 1151803

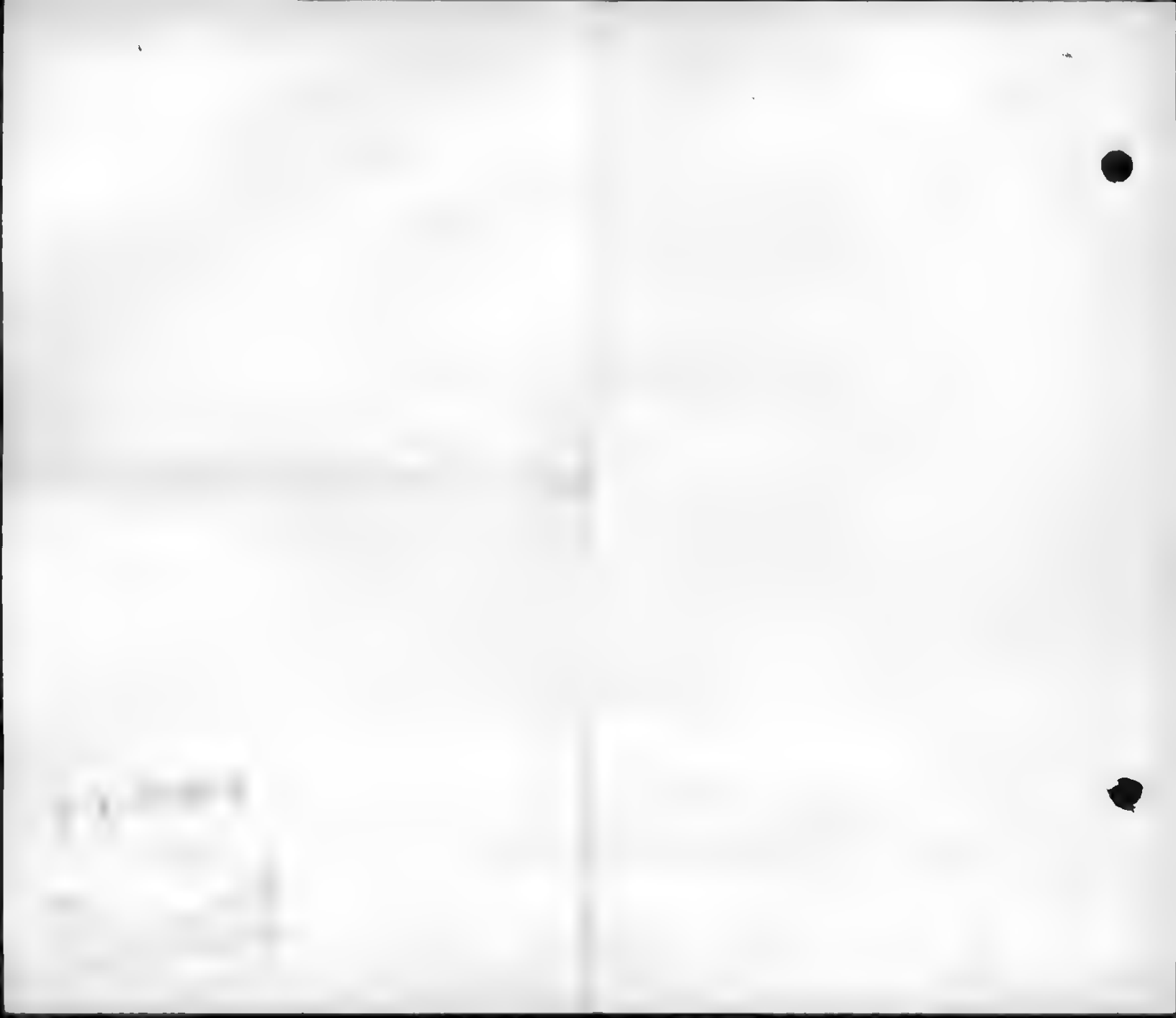
9491

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Ohio</u>	COUNTY <u>Hardin</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Cockeysville</u>	<u>9 months</u>	OR TOWN <u>Ada</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beaver Dam Rd.</u>		STREET ADDRESS (If rural give location) <u>113 So. Johnson St</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Ellen</u>	(Middle) <u>Mauda</u>	(Last) <u>Luft</u>	
(Type or Print)		OF DEATH: <u>October 12</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>16 June 1889</u>
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Allen County Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Hull</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret W. Latham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>Son Paul Harrod, Cockeysville, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
153X IMMEDIATE CAUSE		(A) <u>Carcinoma of Breast</u> over 9 months	
ANTECEDENT CAUSE (B)		(B) <u>Cancer of Ovary</u> about 2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Oct.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11 Oct.</u> , 19 <u>55</u> , and that death occurred at <u>Ada, Mo.</u> from the causes and on the date stated above.			
SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>12 Oct 1955</u>	
M. D. <u>Cockeysville</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Oct. 12, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Chiles Funeral Home</u>		LOCATION (City, town, or county) (State) <u>Lima, Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR <u>13 October 1955</u>		REGISTRAR'S SIGNATURE <u>Anne Armistead MacRae</u>	
FUNERAL DIRECTOR <u>John Burns</u>		ADDRESS <u>So. Johnson, Ind.</u>	

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10557

9492

CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>(Rural) Woodlawn</u>				OR TOWN <u>Woodlawn (Rural)</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dogwood Road</u>				STREET ADDRESS (If rural give location) <u>Dogwood Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
SARAH MARGARET MacKENZIE				Oct. 23, 1955			
5. SEX		6. COLOR OR RACE:		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):		8. DATE OF BIRTH:	
Female		White		Widow		Sept. 27, 1874	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Virginia		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
? Hannon				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No				None		Woodlawn - 7, Md. Miss Adelaide MacKenzie Dogwood Rd	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) Carcinomatous							
DUE TO							
(B) Carcinoma of Intestine (Large)							
DUE TO							
(C) Cardio-Vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
1955 / 1				As above			
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 1924, 19, to 10/23/1955 that I last saw the deceased alive on 10/22/1955, and that death occurred at 10 P M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Mr. E. Martey		M. D. Ponder, Catonsville, Md.		10/24/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Oct. 26, 1955		Good Sheppard Cemetery		Ellicott City, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10/24/55		Mr. E. Martey		Easton, Sons		Catonsville, Md.	



9493

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>FORT HOWARD</u>		<u>47</u> days		TOWN <u>BALTIMORE</u> <u>32014</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>2211 DUKER COURT</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>JOSEPH E. MACKEY</u>				OF DEATH: <u>OCTOBER 8, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>2-4-97</u>	<u>58</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>SALESMAN</u>		<u>ROOFING</u>		<u>CHURCH HILL, MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>PETER MACKEY</u>				<u>ANNA USILTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>WW - 1L</u>				16. SOCIAL SECURITY NO. <u>218-07-3343</u>		17. INFORMANT & ADDRESS.	
				<u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF LUNG</u>						<u>7 MONTHS</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>RHEUMATIC HEART DISEASE.</u>						<u>12+ YEARS</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 22, 1955, to Oct. 8, 1955, and that death occurred at 2:40 PM, from the causes and on the date stated above.</u>							
SIGNATURE <u>William E. Hill, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>10-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <input checked="" type="checkbox"/>		24. FUNERAL DIRECTOR <u>LILLY & ZELLER FUNERAL HOME</u>		ADDRESS <u>1901 Eastern Ave., Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09485

9494

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>50 TOWN</u> HOSPITAL OR INSTITUTION OR House of Pines Nursing Home STREET ADDRESS <u>1</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>15 TOWN</u> <u>Havre de Grace</u> STREET ADDRESS (If rural, give location) <u>North Stokes St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Joseph</u> (First) <u>G</u> (Middle) <u>Mackin</u> (Last)	4. DATE OF DEATH <u>10</u> (Month) <u>20</u> (Day) <u>1955</u> (Year)	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Civil Engineer</u>	8. DATE OF BIRTH <u>6-16-1888</u>	9. AGE last birthday <u>67</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Joseph Mackin</u>	14. MOTHER'S MAIDEN NAME <u>Mary Crane</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 443X

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Myocardial infarction(b) Myocardial infarction

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 1955, to 10-20-55, that I last saw the deceasedalive on 10-20-55, 1955, and that death occurred at 10-20-55 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William K. Gallager M.D. Catonsville 28, Md.10-20-55

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10/21/55W.E. HarryPennington & Son, 225 S. Washington St.Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **1** hours after death. The below copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9495

CERTIFICATE OF DEATH

09486

Reg. Dist. No. *1*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Hydco (Rural)</i>		<i>4-5</i>		TOWN <i>Hydco (Rural)</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Elder Rd.</i>				STREET ADDRESS (If rural give location) <i>Elder Rd.</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>L C I S W A D E M A C R U M</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>10-26-1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>1-4-1865</i>		9. AGE last birthday <i>90</i> yrs.	IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm Wade</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Hoopes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT & ADDRESS <i>L. H. Elder, Hydco, Md.</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1 IMMEDIATE CAUSE (A) Coronary Occlusion</i>				<i>20 min</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>(B) ---</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>(C) ---</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <i>Walter H. Thompson</i>				ADDRESS (Street, city, town, state) <i>Baltimore, Md.</i>		DATE SIGNED <i>10-26-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		DATE THEREOF <i>10-28-55</i>		NAME OF CEMETERY OR CREMATORY <i>Freemantle</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Walter H. Thompson</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>L. Scott Brooks Sparks</i>		ADDRESS <i>Md.</i>	
DATE <i>10-21-55</i>							



9381

CERTIFICATE OF DEATH

09487

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Dundalk LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 275 Baltimore Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY
 CITY (If outside corporate limits, write RURAL, and give nearest town) Dundalk
 STREET ADDRESS (If rural give location) 275 Baltimore Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

CARLO

MARCOMIN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

October 27 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

Widowed

Sept. 23, 1877

78

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Dominick Marcomin

14. MOTHER'S MAIDEN NAME:

Dominica ?

15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Albert Marcomin 275 Baltimore Ave-22

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X
Immediate cause(a) Carcinoma of Stomach
DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)
DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Sept. 1954 to 10/27, 1955, that I last saw the deceasedalive on 10/26, 1955, and that death occurred at 12 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Oct 31-1955 William M KellyUllrich Funeral Home 2112 Dundalk Ave.,

MARGIN RESERVED FOR BINDING

W/A 100

100

9496

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Essex</u> <u>54</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sp. Pt. Hospital</u>		STREET ADDRESS (If rural, give location) <u>24 Hagner Lane</u>	
3. NAME OF DECEASED (Type or Print) <u>Spinn</u> (First) <u>masson</u> (Last)		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>31</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-13-1896</u>
9. AGE last birthday <u>59</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Balto. Co.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME <u>Charles L. Masson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Isadore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>246-63-6086</u>	
17. INFORMANT AND ADDRESS <u>Julia L. Masson (wife)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. INJURY PLACE (Home, farm, factory, street, office bldg, etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

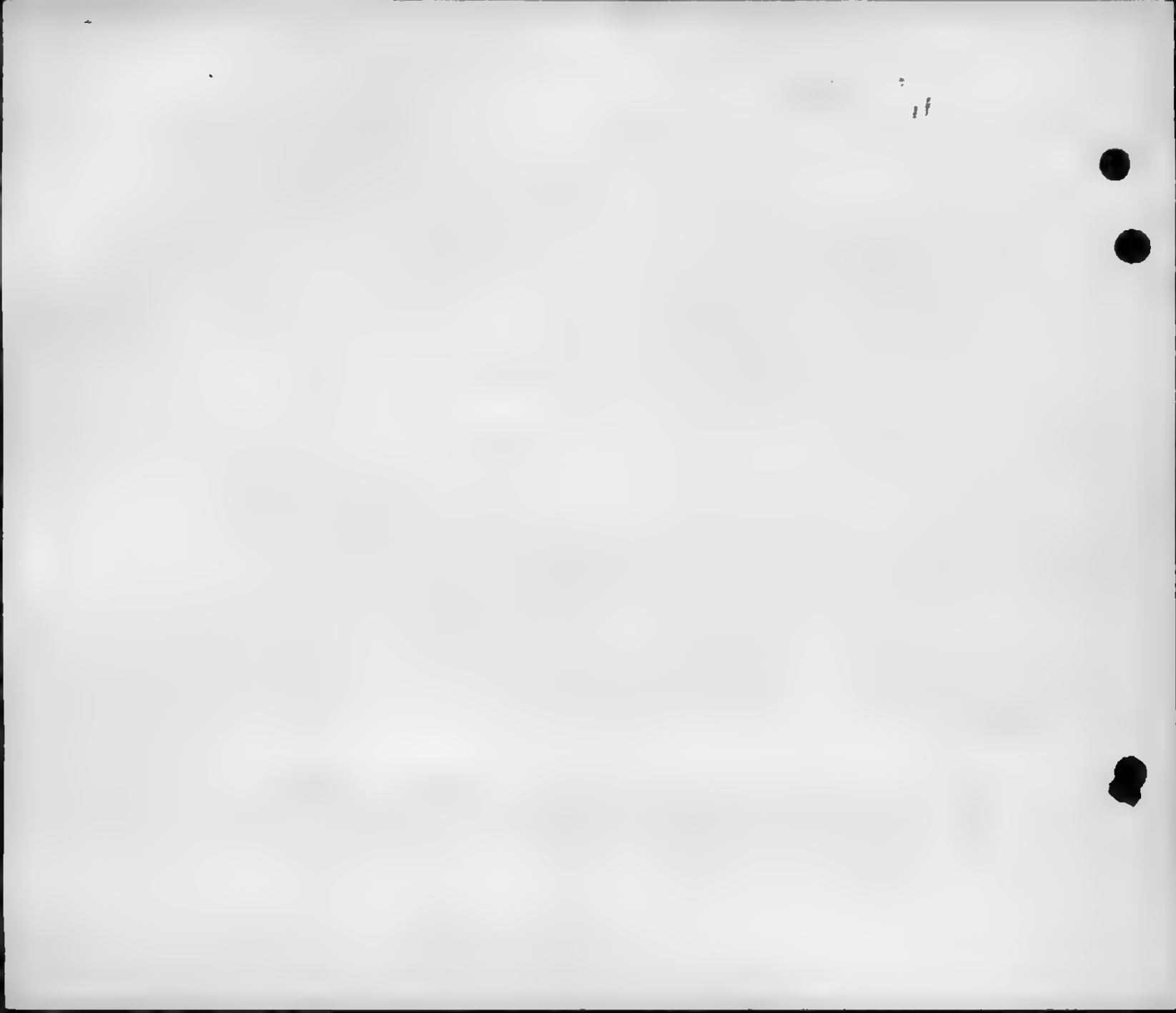
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9382

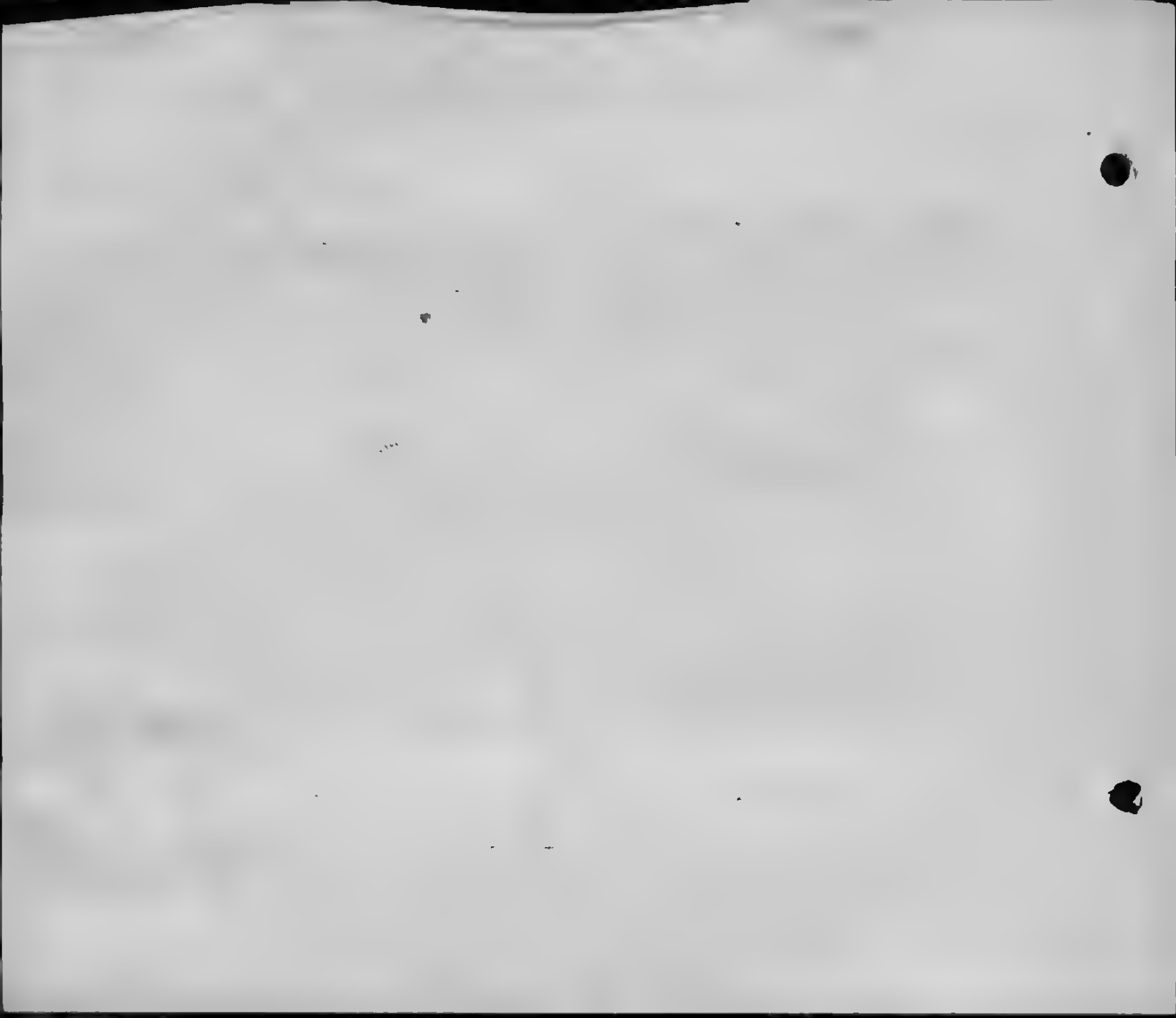
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09489
Reg. Dist.

No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN DUN OAK		LENGTH OF STAY (In this place) 2 1/2 yrs.		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore SPARROWS POINT (14)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastern Ave. West of North Point Road				STREET ADDRESS (If rural, give location) 1223 Forest Road			
3. NAME OF DECEASED: (Type or Print)		(First) George		(Middle) JOHN		(Last) MATTOLIA	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: Jan 16, 1932	
9. AGE last birthday: 23 yrs.		10. a. OCCUPATION (Give kind of work done during most of work life, even if retired): ARMY		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): PENNA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME: MICHAEL M. TOLIA			
14. MOTHER'S MAIDEN NAME: JOSEPHINE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): NO			
16. SOCIAL SECURITY No.: 191-22-9386				17. INFORMANT & ADDRESS: JOSEPHINE MATTOLIA - SM			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... Crushed Chest DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Street		21c. (City or town) (County) (State)			
Baltimore Maryland							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/14/55 2:35 AM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Speeding auto - out of control			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Merri		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. 10/14/55					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF 10-17-55		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE Mrs. Edith H. Hickey		24. FUNERAL DIRECTOR		ADDRESS	



9497

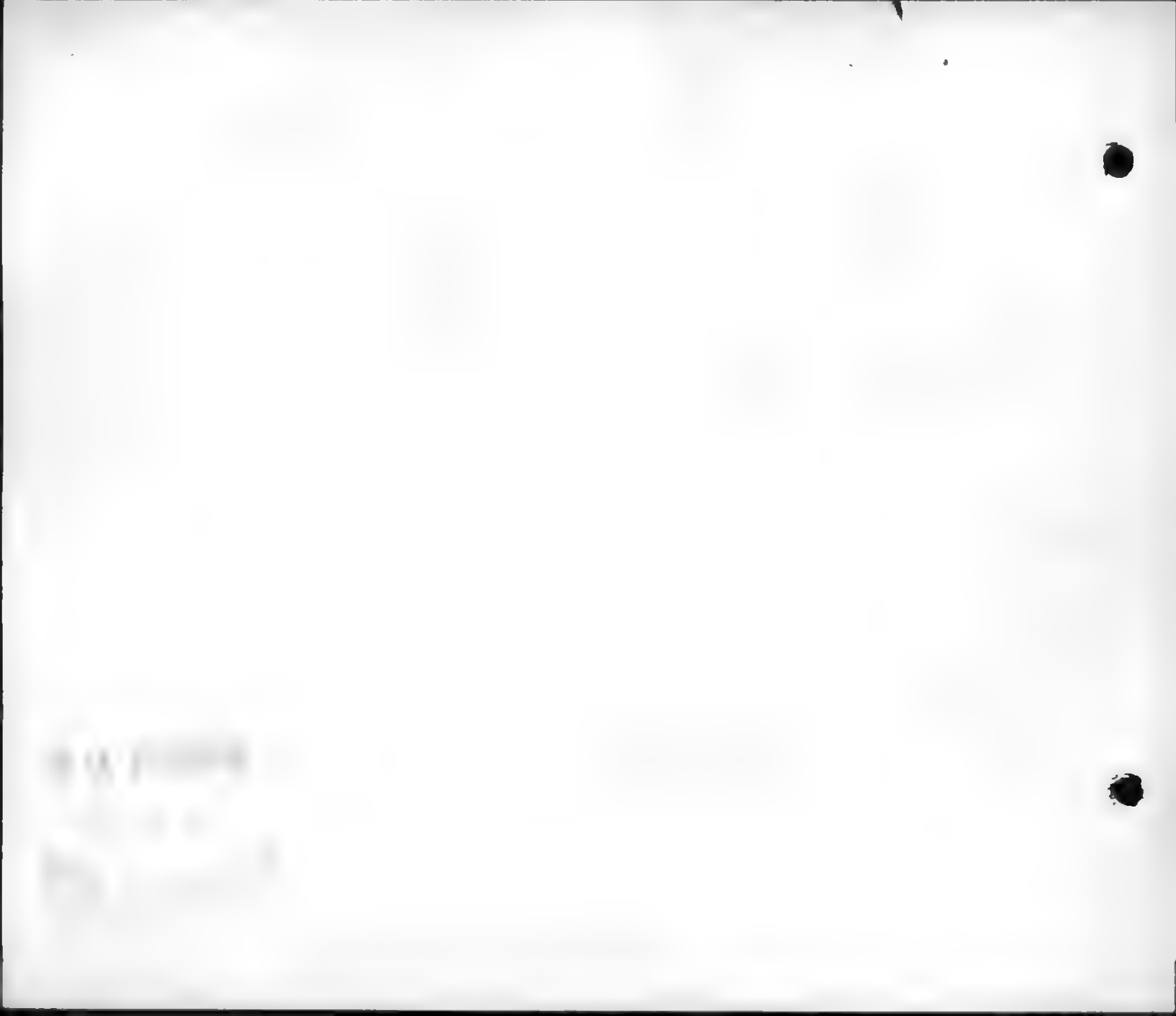
CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Owings Mills</u>		OR TOWN <u>Owings Mills</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>28 Wingate Road</u>		<u>28 Wingate Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Anna G. McBride</u>		<u>Oct. 26 19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Dec. 25, 1903</u>
9. AGE last birthday: <u>51</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William T. Stinchcomb</u>		14. MOTHER'S MAIDEN NAME: <u>Helen M. Gemp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-8905</u>	
17. INFORMANT & ADDRESS: <u>Albert V. McBride, 28 Wingate Rd.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
410 X IMMEDIATE CAUSE		<u>Cerebral Embolus</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>Plummer Heart Disease & Aortic Stenosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO <u>+ coronary atherosclerosis, Mitral Stenosis & insuff.</u>	
		DUE TO <u>Arterial Sclerosis & Fibrosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/24</u> , 19 <u>55</u> , to <u>10-26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-25</u> , 19 <u>55</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Sam Ashman</u>		DATE SIGNED <u>10-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 29, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/27/1955</u>		REGISTRAR'S SIGNATURE <u>Dorothy A. Powell</u>	
24. FUNERAL DIRECTOR <u>Frederick H. Powell</u>		ADDRESS <u>Lithmanville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

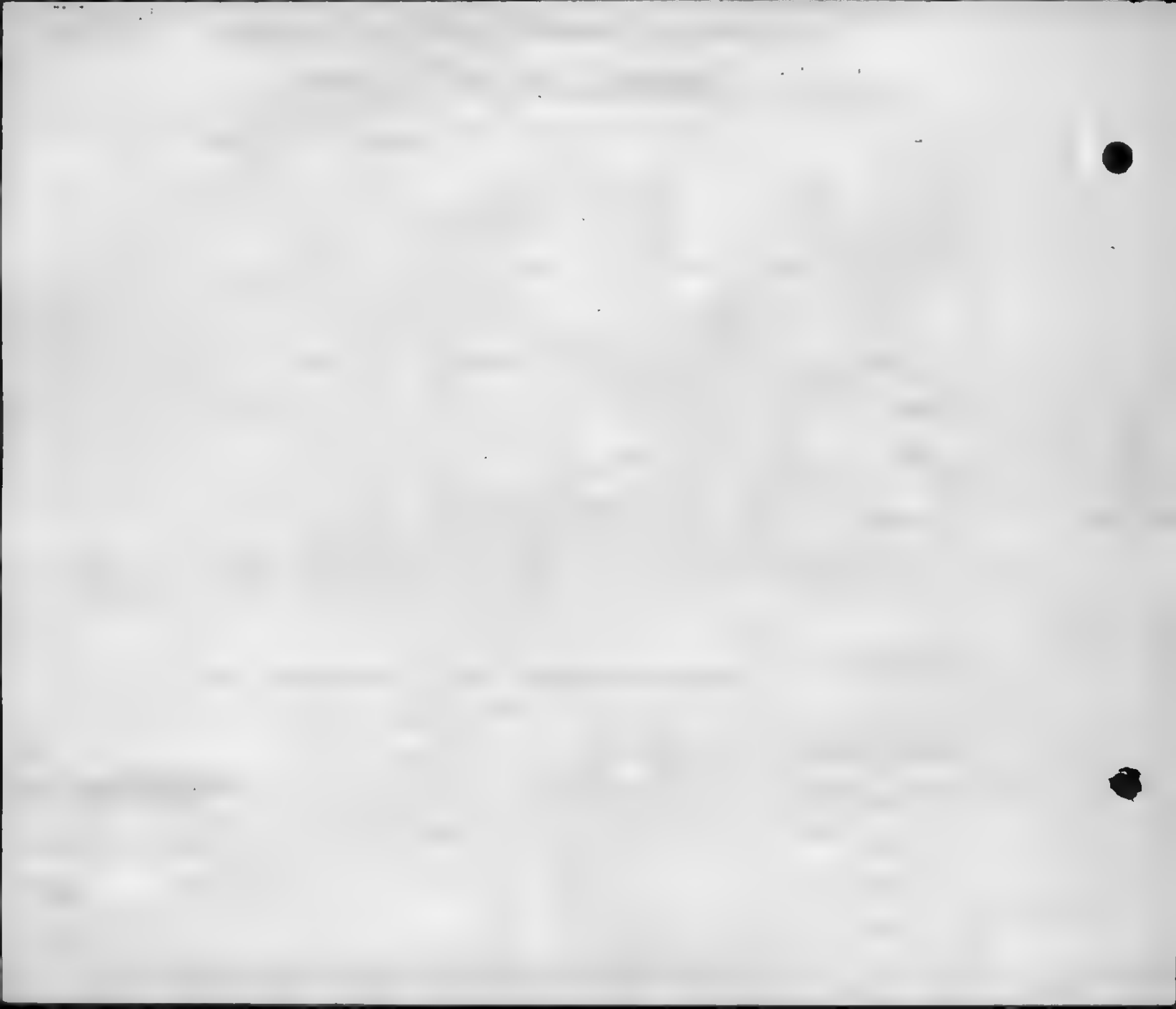
2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
OR TOWN <u>JONES' CREEK (19)</u>		LENGTH OF STAY (in this place) <u>12 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>JONES' CREEK (19)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2413 KETCHUM AVE.</u>				STREET ADDRESS (If rural give location) <u>2413 KETCHUM AVE</u>			
3. NAME OF DECEASED (Type or Print) <u>ARTHUR WILLIAM MCFARLAND</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>10-30-1953</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>FEB 11, 1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORM WINDOW</u>		9. AGE last birthday <u>55</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>	
13. FATHER'S NAME <u>Wm. MCFARLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>567-03-3833</u>		17. INFORMANT & ADDRESS <u>CATHERINE W. MCFARLAND</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Cigarette Coronary Insufficiency</u>						<u>1 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 30</u> , 19 <u>53</u> , to <u>Oct. 30</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Oct. 30</u> , 19 <u>53</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>570 D St. Balt. 19 Md.</u>		DATE SIGNED <u>11-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>11-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dawson D. Truher</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Arthur Bradley</u>		ADDRESS <u>Rivdale, Md.</u>	
DATE <u>Nov. 2-55</u>							



9499

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE MARYLAND				STATE MD. COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) 53 TOWN				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE 3614			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE STATE HOSP.				STREET ADDRESS (If rural give location) 1618 N. BENTALOU ST.			
3. NAME OF DECEASED: (First) CORA		(Middle) M.		(Last) Mc Dermitt		4. DATE (Month) (Day) (Year) OF DEATH: 10 12 1955	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED	8. DATE OF BIRTH: 3-5-1880	9. AGE last birthday: 75 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	IF UNDER 64 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ? S WIVLEY				14. MOTHER'S MAIDEN NAME: MILDRED KOONTA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. no		17. INFORMANT & ADDRESS: MRS. FRANK MULLIGAN, 3143 W. NORTH AV. BALTO.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 321X							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) CEREBRAL VASCULAR ACCIDENT						10/3/55	
(B) ARTERIOSCLEROSIS						to	
(C)						10/12/55	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 4 , 19 55 , to Oct. 12 , 19 55 , that I last saw the deceased alive on 10-13-55 , and that death occurred at 8 P. M. from the causes and on the date stated above.							
SIGNATURE Stella Wachler		ADDRESS M.D. S. B. St. H.		DATE SIGNED 10/12/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/15/55		NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR 10-13-55		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR [Signature]		ADDRESS [Address]	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9500

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town 3700 Olden Drive
 TOWN Lochearn
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
 STREET ADDRESS (If rural give location) 3700 Olden Drive - Lochearn

3. NAME OF DECEASED:

(First) Arthur (Middle) - (Last) McLean, Sr.
 (Type or Print)

4. DATE OF DEATH: (Month) Oct (Day) 9 (Year) 1955

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Widowed

8. DATE OF BIRTH:

6-22-1870

9. AGE last birthday: 85 yrs. IF UNDER 1 YEAR: Months 9 Days 9 Hours 19 Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Photographer

10b. KIND OF BUSINESS OR INDUSTRY:

Chicago Tribune

11. BIRTHPLACE (State or foreign country):

MD.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME:

Arthur McLean

14. MOTHER'S MAIDEN NAME:

Ruth E. Hobbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

Unk.

17. INFORMANT & ADDRESS:

Mr. E. Edward McLean - 3700 Olden Drive

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

433x
 Immediate cause

(a)

Concurrent Heart Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Chronic Bronchitis

(c)

Generalized Atherosclerosis

Interval Between Onset And Death

one dayone week3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1950, to Oct 9, 1955, that I last saw the deceased

alive on Oct 8, 1955, and that death occurred at 7:45 P.M. from the causes and on the date stated above.

SIGNATURE Edwin Y. Vincent, M.D.

ADDRESS

8204 Eubank Rd. Balto 7, Md.

DATE SIGNED

10/10/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

10-12-55

NAME OF CEMETERY OR CREMATORY

Trinity View

LOCATION (City, town, or county)

Severna Park, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

Oct. 11, 1955

REGISTRAR'S SIGNATURE

Wm. E. Marten

24. FUNERAL DIRECTOR

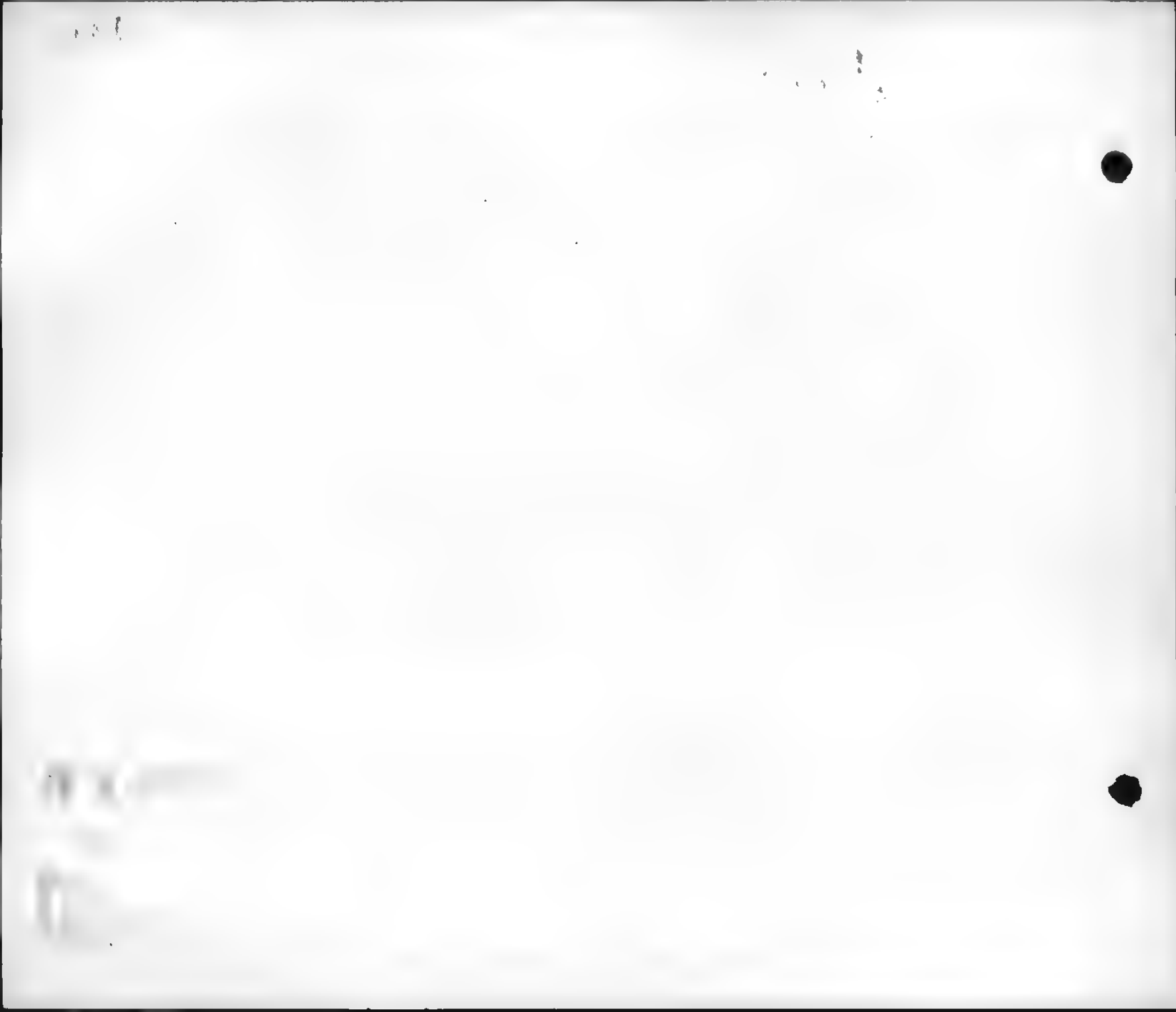
Arthur N. Hargett - Sykesville, Md.

ADDRESS

Sykesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



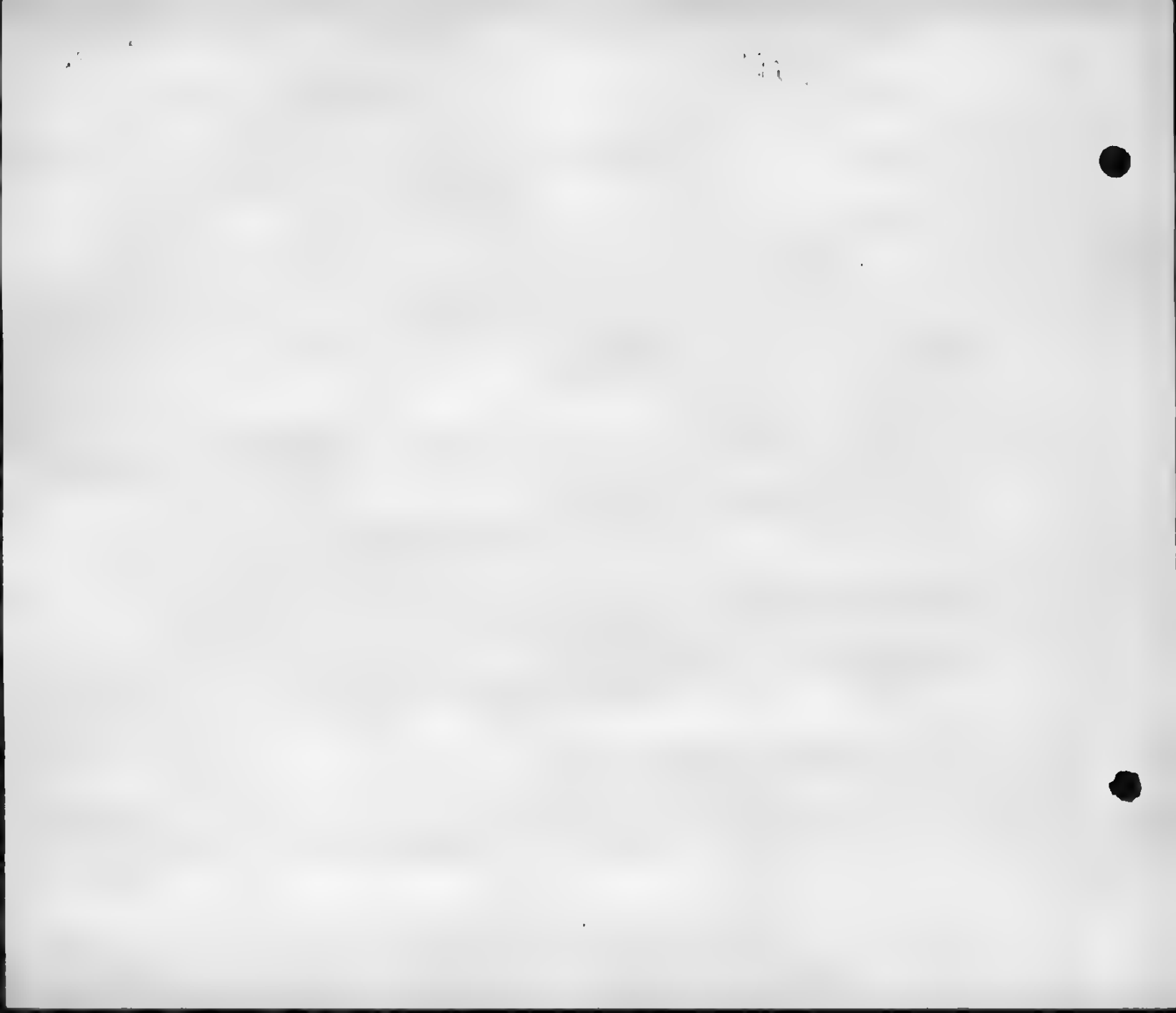
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09494

1 9501 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ca Connville</u>				TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>1840 W. Pratt Street</u>			
3. NAME OF DECEASED: (First) <u>ELLER</u>		(Middle)		(Last) <u>Mc Manus</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>14</u> <u>1955</u>	
5. SEX: <u>P</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>December 1878</u>		9. AGE last birthday: <u>76</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Cyril K Murphy Jr - 1508 West 7th St BK</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) DUE TO <u>Infective pneumonia</u>						5 days	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO <u>Pulmonary thrombosis</u>						5 days	
(C) <u>Arteriosclerotic cardiovascular disease</u>						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/1</u> , 19 <u>53</u> , to <u>10/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/14</u> , 19 <u>55</u> , and that death occurred at <u>10.15 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Wachter</u>		M. D. <u>Spring Grove St. Hosp.</u>		DATE SIGNED <u>10/16/1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>Oct 18-1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-17-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Immortal Inc. 1217 St James St</u>		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09495
9592 CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn</u>		LENGTH OF STAY (in this place) <u>40 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2023 Russell Ave.</u>				STREET ADDRESS (If rural give location) <u>2023 Russell Ave.</u>			
3. NAME OF DECEASED: (First) <u>Howard</u> (Middle) <u>Arestess</u> (Last) <u>Merson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct.</u> <u>23</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 23, 1896</u>	9. AGE last birthday: <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>19</u>	IF UNDER 24 HRS. Days <u>55</u>	Hours <u>19</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bookkeeper</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Produce Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Savage, Md.</u>	
13. FATHER'S NAME: <u>Paul Merson</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth A. Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>213-05-5261</u>		17. INFORMANT & ADDRESS: <u>Clara M. Merson - 2023 Russell Ave.</u>	
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>9/2</u> , 19 <u>55</u> , to <u>10/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>55</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Milton Schlenoff</u>		ADDRESS <u>M.D. 6410 Windsor Mill Rd</u>		DATE SIGNED <u>Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Hgts. Ave</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9503

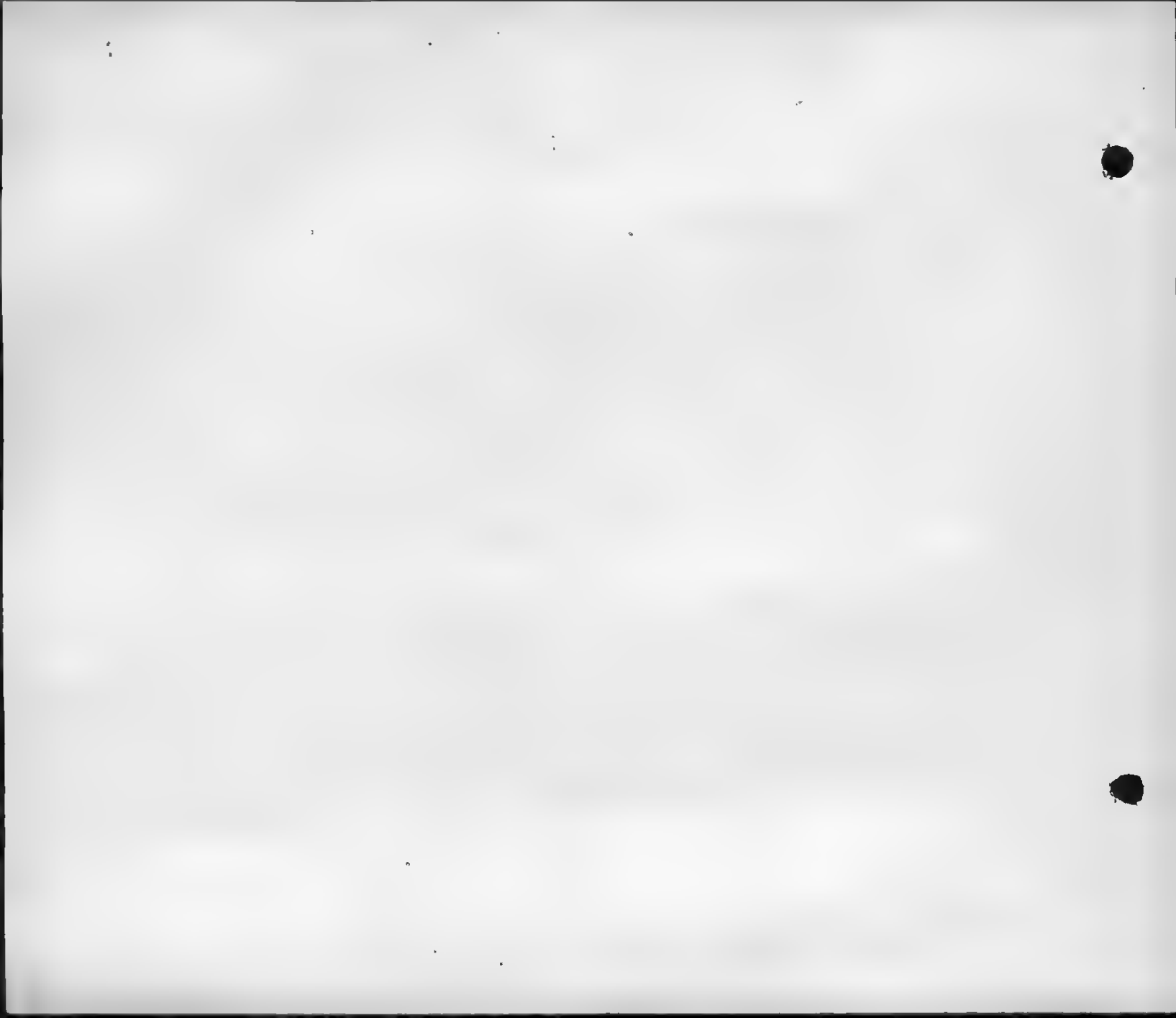
CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH— COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HARBOR VIEW</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>500 S. 48th St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HARBOR VIEW</u> STREET ADDRESS (If rural give location) <u>500 S. 48th St.</u>	
3. NAME OF DECEASED: (First) <u>ANNA</u> (Middle) <u>THEODORE</u> (Last) <u>MILLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>OCT.</u> <u>1</u> <u>1955.</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>June 21 1863</u>
9. AGE last birthday <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOUSE WORK</u>	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>? MILLER</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>--</u> If Yes, give war or dates of service: <u>--</u>		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS: <u>Henry C. Koos 500 S. 48th St.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
154X IMMEDIATE CAUSE		(A) <u>Malignancy of Rectum</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
ANTECEDENT CAUSE (B):		(B) <u>Elephantiasis</u>	<u>15 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Hypertrophic Arthritis</u>	<u>30 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>35</u> , to <u>Oct 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>55</u> , and that death occurred at <u>12:45 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Marie A. Jacob M.D.</u>		DATE SIGNED <u>10/2/55</u>	
M.D. <u>1010 NORTH Point Rd. Balt.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-4-55</u>	
NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>		LOCATION (City, town, or county) <u>ANNAPOLIS RD., MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-3-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>901 S. LONGKING ST. BALTO., MD.</u>	



9524

CERTIFICATE OF DEATH

Reg. Dist. No.

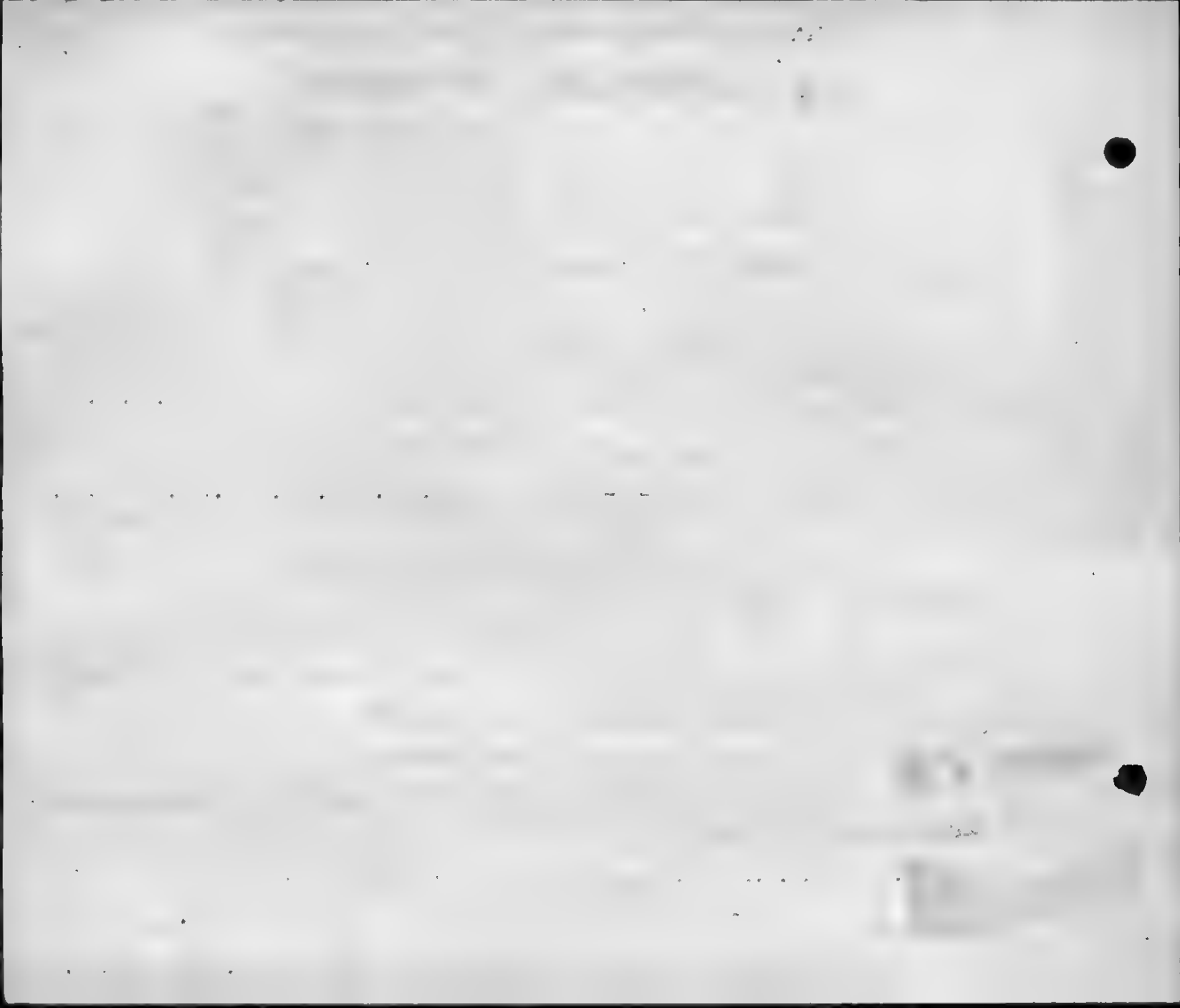
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Fort Howard</u>		<u>20 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>328 W. Camden Street</u>			
3. NAME OF DECEASED (Type or Print) <u>JOSEPH F. MILLER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 24, 19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>4/10/87</u>	
9. AGE last birthday <u>68</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Can Company</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Dailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>214-03-2430</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>4521</u> IMMEDIATE CAUSE (A) <u>HEMORRHAGE, CEREBRAL</u>						<u>3 WEEKS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PULMONARY EMPHYSEMA</u>						<u>UNKNOWN</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 4, 19 55</u> to <u>October 24, 19 55</u> and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey M.D., Chief, Medical Service</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>10-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE <u>Dr. D. L. Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Dabrowski</u>	
DATE <u>10-27-55</u>				ADDRESS <u>2818 E. Baltimore, St. Baltimore, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M



1266
MARYLAND

9505

CERTIFICATE OF DEATH

09498
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1501 SUMMIT AVE</u>		STREET ADDRESS (If rural, give location) <u>1501 SUMMIT AVE</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>LOUISE</u>	(Last) <u>MILLER</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 3, 1923</u>
9. AGE last birthday <u>72</u> yrs.		4. DATE OF DEATH (Month) <u>10</u> (Day) <u>15</u> (Year) <u>1993</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD OETERS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE O'NEKE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Harry L. Miller Jr. 1501 Summit Ave.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Myocardial failure</u>				5 days	
Antecedent cause(s) (b) <u>ASCVD</u>				Unknown	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-3 1997, to 10-15 1995, that I last saw the deceased alive on 10-15 1995, and that death occurred at 1455 P m, from the causes and on the date stated above.

SIGNATURE Stephen L. Maynard M.D. ADDRESS Catonsville, Md DATE SIGNED 10-17-95

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 10-18-95 NAME OF CEMETERY OR CREMATORY Cathedral Cems. LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REG. 10/17/95 REGISTRAR'S SIGNATURE V.E. Barry 24. FUNERAL DIRECTOR Grady Funeral Home - Catonsville, Md. ADDRESS

MARGIN RESERVED FOR BINDING

U.S. AIR FORCE

101

500-050

9506

CERTIFICATE OF DEATH

Reg. Dist. No. 58

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits, write RURAL, and give nearest town) TOWSON (in this place)
OR TOWN 3 Mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 11 HILLSIDE AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY BALTO.
CITY (If outside corporate limits, write RURAL, and give nearest town) TOWSON
OR TOWN 11 HILLSIDE AVE
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) MATTIE (Middle) P. (Last) MILLER

4. DATE OF DEATH: (Month) OCT. (Day) 1 (Year) 1955

5. SEX:

FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH: SEPT. 29, 1869

9. AGE last birthday: 86 yrs. If UNDER 1 YEAR: Months: Days: Hours: Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life.

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): LEWISTOWN MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

JACOB P. WELLER

14. MOTHER'S MAIDEN NAME:

JOANNA WEBB

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

MR. G. P. TOFFORD

17. INFORMANT & ADDRESS: 11 HILLSIDE AVE TOWSON-4-MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X

Immediate cause

(a) DUE TO

Carcinoma Pancreas

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 20, 1955, to Oct. 1, 1955, that I last saw the deceased

alive on Oct. 1, 1955, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

SIGNATURE Laurence C. Post

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, (Specify)

DATE THEREOF OCT. 4, 1955

NAME OF CEMETERY OR CREMATORY UTICA CHURCH CEM.

LOCATION (City, town, or county) FREDERICK Co. MD.

(State)

DATE REC'D. BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE John Redwood

24. FUNERAL DIRECTOR

ADDRESS

10-4-55 Henry H. Jenkins & Co 4905 York Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9517

CERTIFICATE OF DEATH

Reg. Dist. No. 30

09500

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>514 Cathedral Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna V. Mitchell</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>October 14, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3-21-1896</u>
9. AGE last birthday: <u>59</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME: <u>Isadore Marnsdue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>		<u>3 months</u>	
ANTECEDENT CAUSE (B) <u>Adenocarcinoma descending colon</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-26-</u> , 19 <u>55</u> to <u>10-14-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-14-</u> , 19 <u>55</u> , and that death occurred at <u>4:35P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Spella Wachler</u>		DATE SIGNED <u>10-14-55</u>	
23. BURIAL CREMATION REMOVAL (SPECIFY) <u>Crema</u>		NAME OF CEMETERY OR CREMATORY <u>Balts. National Cem.</u>	
DATE THEREOF <u>10/18-55</u>		LOCATION (City, town, or county) (State) <u>Balts. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/17/55</u>		24. FUNERAL DIRECTOR <u>Tracy Funeral Home - Catonsville, Md.</u>	

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CERTIFICATE OF DEATH

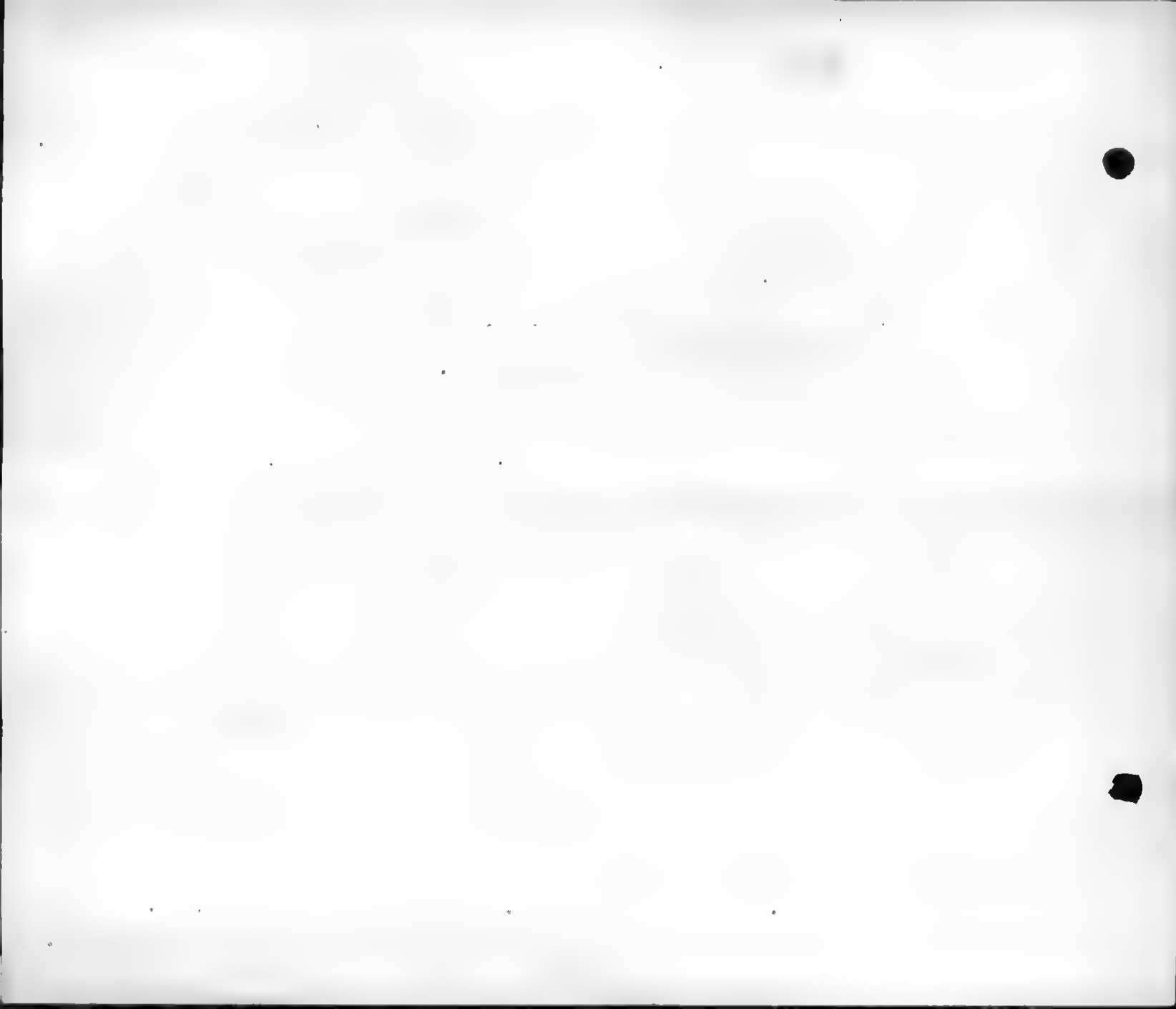
Reg. Dist. No.

41

1. PLACE OF DEATH: COUNTY <u>3122 Dunglew Road</u> CITY (If outside corporate limits, write name and give nearest town) <u>Balto. Dundalk</u> OR TOWN <u>Dundalk</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3122 Dunglew Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: <u>3122 Dunglew Rd. Dundalk</u> STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write name and give nearest town) <u>Dundalk</u> OR TOWN <u>Dundalk</u> STREET ADDRESS (If rural give location) <u>3122 Dunglew Road 22</u>	
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Page H. Mitchell</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Oct. 16, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 1st. 1887</u>
9. AGE last birthday: <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>19</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>retired (Grocery)</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>retired</u>	
11. BIRTHPLACE (State or foreign country): <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Mitchell</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Mrs. Catherine Mitchell, 3122 Dunglew Rd. 22</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Interval Between Onset And Death <u>6 months</u> <u>5 yrs.</u>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Ceph</u> , 19 <u>55</u> , to <u>16 Oct</u> , 19 <u>55</u> that I last saw the deceased alive on <u>16 Oct</u> , 19 <u>55</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above. SIGNATURE (Degree or title) <u>Ben Saward M.D.</u> ADDRESS <u>2900 Dunbar Rd</u> DATE SIGNED <u>10-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Oct. 19/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-17-55</u>		REGISTRAR'S SIGNATURE <u>Philp H. Hewig, Sr.</u>	
GENERAL DIRECTOR <u>Philp H. Hewig, Sr.</u>		ADDRESS <u>2024 Orleans St. 31</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809502

9598 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>10, 24</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Villa Nova</u>		OR TOWN <u>Pikesville</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Robb Nursing Home 1105 Essez Rd.</u>		STREET ADDRESS (If rural give location)	
		<u>305 Reisterstown Rd.</u>	1
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 28, 19 55</u>	
<u>MARVIN HERBERT MOORE</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>divorced</u>	8. DATE OF BIRTH: <u>April 27, 1903</u>
9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Oil Co.</u>	11. BIRTHPLACE (State or foreign country): <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>George R. Moore</u>		14. MOTHER'S MAIDEN NAME: <u>Effie E. Gosnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Pikesville, Md. Mrs. Mildred Krumm - 305 Reisterstown Rd.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Hemorrhage from carotid artery</u>			<u>in minutes</u>
ANTECEDENT CAUSE (B) <u>Cancer of the Pharynx</u>			<u>2 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>10/26/55</u>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/26, 1955</u> , to <u>Oct 27, 1955</u> , that I last saw the deceased alive on <u>10/26, 1955</u> , and that death occurred at <u>8 30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Harri Salzman</u>		DATE SIGNED <u>10/29/55</u>	
M. D. <u>1413 Reisterstown Rd Pikesville</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/31/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10/29/55</u>		REGISTRAR'S SIGNATURE <u>Chas. J. Dickner</u>	
		24. FUNERAL DIRECTOR <u>Chas. J. Dickner & Sons</u>	
		ADDRESS <u>Balto 17 No</u>	

9599

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		STATE <u>MD.</u> COUNTY <u>BALTIMORE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> 54	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>307 MARGARET</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location) <u>307 MARGARET Ave.</u>			
3. NAME OF DECEASED: (First) <u>GRACE</u> (Middle) (Last) <u>MOSES</u>				4. DATE OF DEATH: 10-13 1955			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Single</u>	8. DATE OF BIRTH: 7 1881	9. AGE last birthday: 74 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Boston</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Welfare Board</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause <u>420.1</u> <u>Coronary occlusion</u>		<u>Sudden</u>
(b) Antecedent cause(s) <u>Arteriosclerotic Cardio-Vascular Disease</u>		<u>10 yrs</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>July 1, 1953</u> , to <u>Oct 13, 1955</u> , that I last saw the deceased alive on <u>Oct 13, 1955</u> , and that death occurred at <u>8 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>M. Baumgardner MD</u>		DATE SIGNED <u>10/17/55</u>	
(DEGREE OR TITLE) <u>MD</u>		ADDRESS <u>Baltimore Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		LOCATION (City, town, or county) <u>Essex</u> (State) <u>MD</u>	
DATE THEREOF <u>Oct. 18 - 55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Vincent's</u>	
DATE REC'D BY LOCAL REG. <u>10/18/55</u>		24. FUNERAL DIRECTOR <u>John G. Connelly</u> ADDRESS <u>Essex</u>	
REGISTRAR'S SIGNATURE <u>David Hurley</u>			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

U. S. A. 1955

1955

RECEIVED

09504

MARYLAND

9510

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7803 Wilson Avenue</u>		STREET ADDRESS (If rural, give location) <u>7803 Wilson Avenue #14</u>	
3. NAME OF DECEASED (Type or Print) <u>Mr. Thomas H. Nail</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 6, 1898</u>
9. AGE last birthday <u>57</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Springridge, Mississippi</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. John Nail</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>215-03-8340</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Helen Nail, 7803 Wilson Ave #14</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a) acute coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from Jan 5, 1950, to Oct 16, 1955, that I last saw the deceasedalive on Oct 16, 1955, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, 5305 Harford Road #14

Dr. Sawyer

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09505

9511

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH BALTIMORE				2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND BALTIMORE			
COUNTY MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		STATE MARYLAND		COUNTY BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1600 SHORE RD.		LENGTH OF STAY (in this place) 6 YRS.		CITY (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		STREET ADDRESS (If rural give location) 1600 SHORE RD.	
3. NAME OF DECEASED (Type or Print) ANTHONY JOSEPH NARESKY				4. DATE OF DEATH (Month) (Day) (Year) OCT. 28 19 55			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH JUNE 12, 1899	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRCRAFT MECH.		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT MFG.		11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME ANTHONY NARESKY				14. MOTHER'S MAIDEN NAME HELEN KONSTANCE KUACHAUAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-09-9881		17. INFORMANT & ADDRESS ZELMA NARESKY			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) BRONCHIOGENIC CARCINOMA				BRONCHIOGENIC CARCINOMA vt. lung		10 months	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JAN 4, 19 55 to OCT 18, 19 55 , that I last saw the deceased alive on 10/22, 19 55 , and that death occurred at 7 4 M. from the causes and on the date stated above.							
SIGNATURE G. H. Kolodziej, M.D.		ADDRESS (Street city, town, state) 1825 Eastern Blvd. Balt. 12/28/55		DATE SIGNED 12/28/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF OCT. 31, 1955		NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS		LOCATION (City, town, or county) (State) BALTO. CO. MD.	
24. REC'D BY REGISTRAR DATE 10/28/55		REGISTRAR'S SIGNATURE Edith Hurley		25. FUNERAL DIRECTOR'S SIGNATURE James Bugdzinski		ADDRESS 1461 Eastern Ave	

INSTRUCTIONS

TO ATTENDING PHYSICIAN ON HOSPITAL The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09506

9512

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Baltimore</u>	
3. CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Towson</u>		4. LENGTH OF STAY (in this place) <u>Life</u>	
5. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>617 Debaugh Ave</u>		6. CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
7. NAME OF DECEASED (Type or Print) <u>Jessie</u>		8. STREET ADDRESS (If rural, give location) <u>617 Debaugh Ave</u>	
9. SEX <u>Female</u>	10. COLOR OR RACE <u>White</u>	11. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	12. DATE OF DEATH (Month) (Day) (Year) <u>Oct 11 1955</u>
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		13b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
14. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u>		15. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. FATHER'S NAME <u>Christopher Corcoran</u>		17. MOTHER'S MAIDEN NAME <u>Cynthia Fowble</u>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		19. SOCIAL SECURITY No. <u>NONE</u>	
20. INFORMANT AND ADDRESS <u>Mrs Marie Horton 617 Debaugh Ave</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerotic Heart Disease</u> Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertrophied Heart</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chr. Bronchitis & Asthma</u>		
12a. DATE OF OPERATION	12b. MAJOR FINDINGS OF OPERATION	13. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
14. ACCIDENT SUICIDE HOMICIDE (Specify)	15. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	16. (CITY OR TOWN) (COUNTY) (STATE)
17. TIME (Month) (Day) (Year) (Hour) OF INJURY	18. INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	19. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-7-1954, to 10-11-1955, that I last saw the deceased alive on 10-11-1955, and that death occurred at 12 P.m., from the causes and on the date stated above.

SIGNATURE: Robert H. M.D.

(Degree or title)

ADDRESS

DATE SIGNED 10-12-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	24. DATE OF BURIAL <u>10/12/55</u>	25. NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Cemetery</u>	26. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>
27. DATE REC'D BY LOCAL REG. <u>10-12-55</u>	28. REGISTRAR'S SIGNATURE <u>John H. H. H.</u>	29. FUNERAL DIRECTOR <u>Lorraine Funeral Home</u>	30. ADDRESS <u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1950. M. (100/100) 54.

9384

09507

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brimfield</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Ches. Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70 Wise Ave</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print) <u>William</u>	(First) <u>Frederick</u>	(Month) <u>10</u>	(Day) <u>13</u>
(Last) <u>Neumann</u>	(Year) <u>1955</u>		
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>9/23/1894</u>
9. AGE last birthday: <u>61</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>FARMER</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>GUSTAV NEUMANN</u>	
14. MOTHER'S MAIDEN NAME: <u>EMMA PLITT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>CHARLES NEUMANN, 70 WISE AVE.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
42.2.1 Immediate cause (a)..... DUE TO		<u>Coronary Occlusion</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)..... DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>M. G. Bowers M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/14/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF: <u>10/17/55</u>	NAME OF CEMETERY OR CREMATORY: <u>SCHWARTZ'S CEMT.</u>	LOCATION (City, town, or county) (State): <u>BALTO. MD.</u>
DATE REC'D BY LOCAL REG. <u>10/14/55</u>	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>P.F. Hoffmann</u>	ADDRESS <u>3218 HUDSON ST.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9513

CERTIFICATE OF DEATH

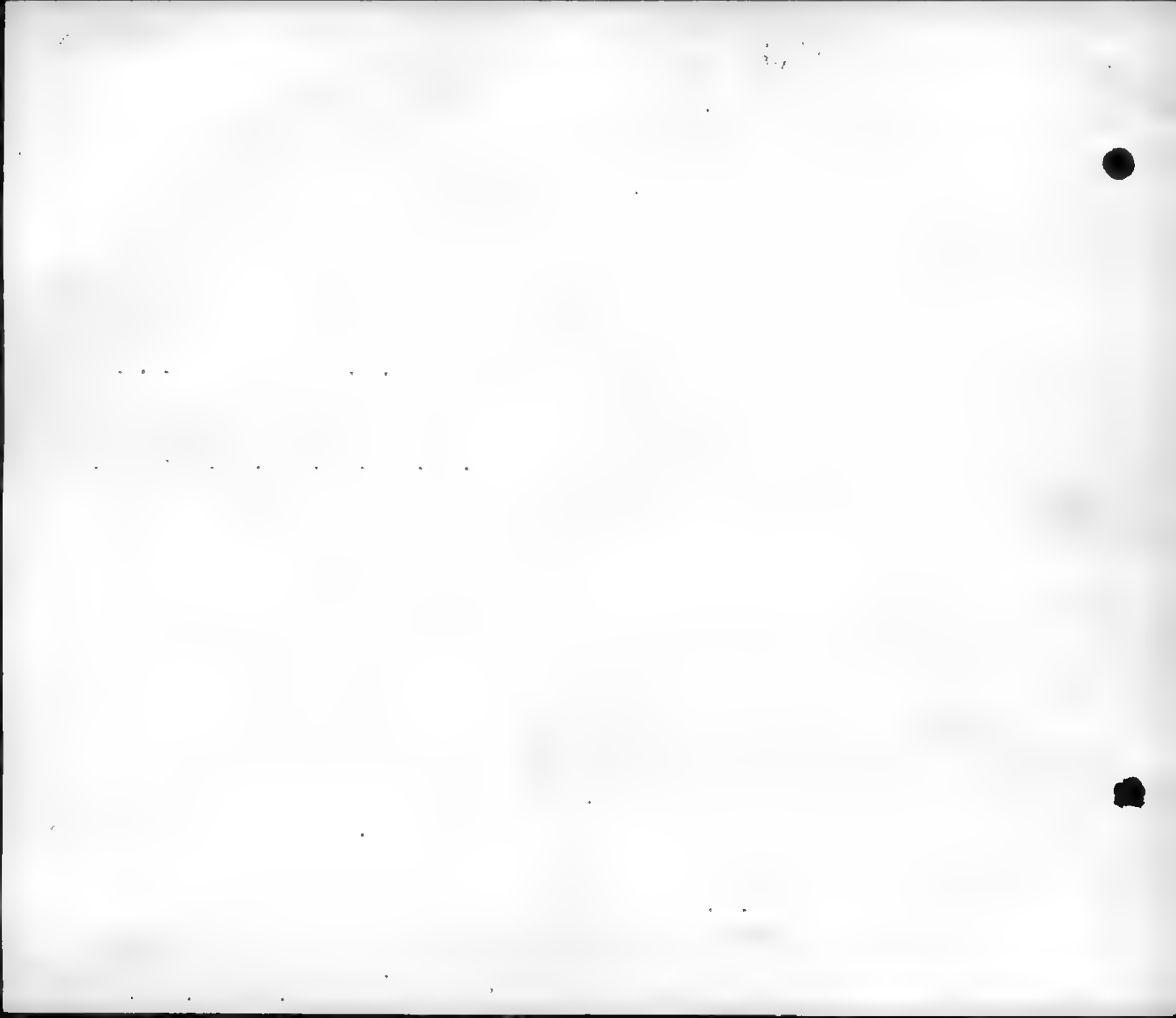
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL) <u>OR</u> TOWN <u>FORT HOWARD</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>BALTIMORE</u> 31014			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>414 LAURENS STREET</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print) <u>RICHARD</u>		<u>(NMI)</u> <u>NICHOLS</u>		OCTOBER 15,		19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>MALE</u>	<u>COLORED</u>	<u>MARRIED</u>	<u>1/11/90</u>	<u>1</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>DRIVER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Drydock</u>		11. BIRTHPLACE (State or foreign country): <u>Plymouth, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ABRAHAM NICHOLS</u>				14. MOTHER'S MAIDEN NAME: <u>SARA BOLDEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>YES</u> (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218-10-1123</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						28 MONTHS	
IMMEDIATE CAUSE (A) <u>CARCINOMA OF BLADDER</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 14, 1955, to Oct. 15, 1955, that I last saw the deceased alive on <u>October 19, 1955</u> , and that death occurred at 3:15 PM, from the causes and on the date stated above.							
SIGNATURE <u>M. D. VAH</u>		ADDRESS <u>FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10-16-55</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>BURIAL</u> <u>10/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>10-12-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>CHARLES L. LAPOUTATY</u>		ADDRESS <u>802 CH MADISON AVE., BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9514

CERTIFICATE OF DEATH

Reg. Dist. No. 09502

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	<u>DISTRICT OF COLUMBIA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>FORT HOWARD</u>	LENGTH OF STAY (in this place) <u>48 DAYS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WASHINGTON</u> <u>47 X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>VETERANS ADMINISTRATION HOSPITAL</u>		STREET ADDRESS (If rural give location) <u>1544 - 25th Street, S. E.</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOHN E. NOBLE</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>OCTOBER 19 19 55</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>3-4-96</u>
9. AGE last birthday <u>59</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>PATHOLOGIST</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>BRANCHVILLE, S. CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>GEORGE M. NOBLE</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>355.1 AMYOTROPHIC LATERAL SCLEROSIS</u>		UNKNOWN	
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT. 1, 19 55</u> , to <u>OCTOBER 19 19 55</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Francis G. Dickey</u>		DATE SIGNED <u>10-20-55</u>	
FRANCIS G. DICKEY, M.D., Chief, Medical Service, VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	
DATE THEREOF <u>10-22-55</u>		LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 20-55</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Parker</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>CHAMBERS FUNERAL HOME</u>	
		<u>17 11th Street, S.E. WASHINGTON D. C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 1/2 000

9515

09510

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 33.

Reg. Dist.

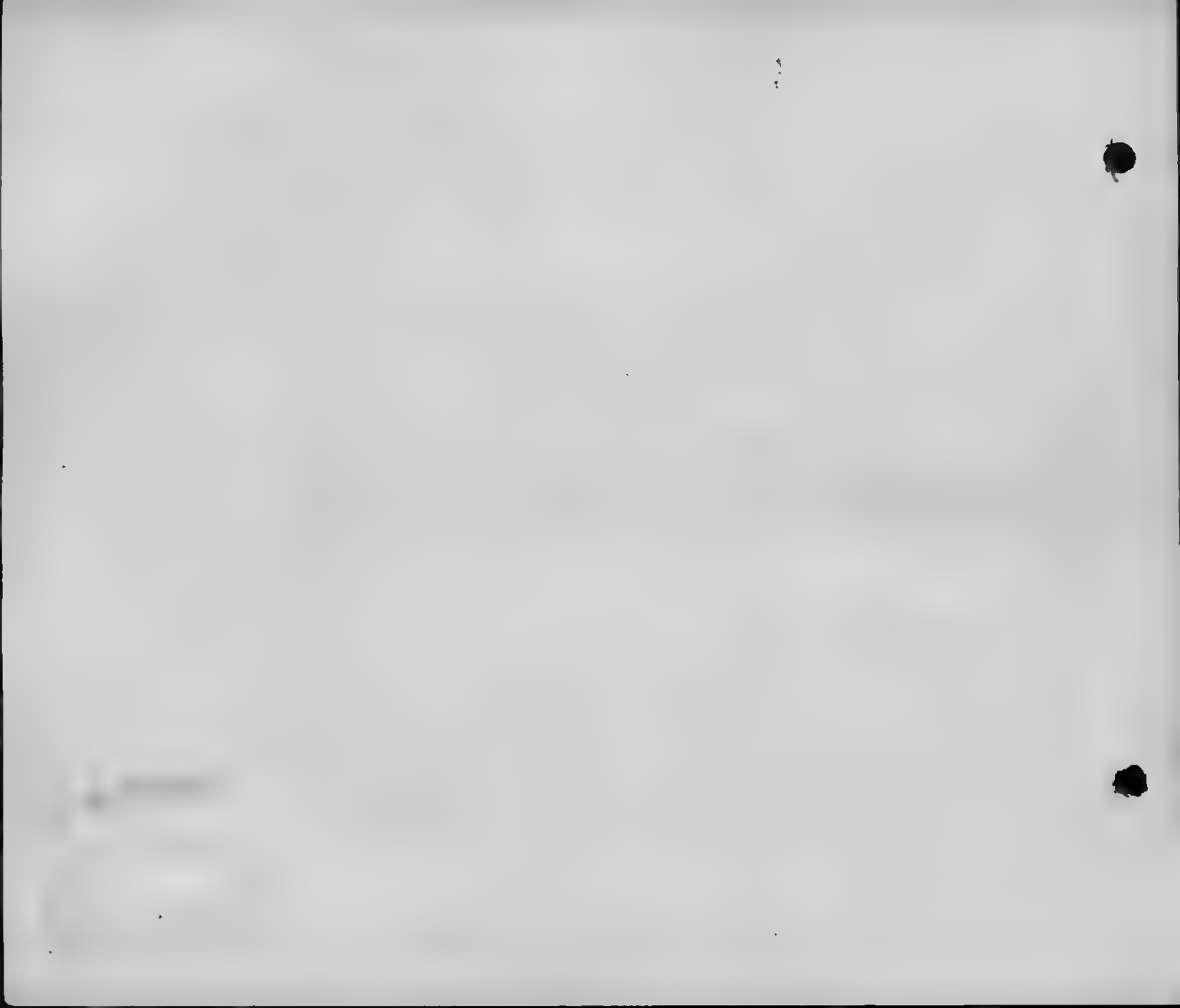
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore	MARYLAND	STATE	md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)		
* TOWN Reisterstown		10 yrs	TOWN Reisterstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
Old Hanover Road			Old Hanover Road		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Thomas	Norris		Oct	19	1955
5. SEX:		6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		
Male		White	Married		
8. DATE OF BIRTH:		9. AGE Last birthday:			
June 26, 1875		80 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Retired Employee of Balto. Co. Roads				England	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME:		
U.S.			Thomas Norris		
14. MOTHER'S MAIDEN NAME:			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		
Jane Rickson			(If Yes, give war or dates of service)		
16. SOCIAL SECURITY No.:			17. INFORMANT & ADDRESS:		
			Margaret U. Norris, Reisterstown, Md.		

18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) ... <u>Fractured Skull (base)</u>					2 1/2 hrs
DUE TO					
Antecedent cause(s) (b) ...					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
None		None			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
		Home		Reisterstown Balto. Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
Oct 19 55 9:36 A.M.				Fall from ladder while painting	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.			
A.D. Caples		10/24/55			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Oct. 21/55		New Cathedral	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
10-21-55		Mary B. Eline		J.F. Eline & Sons, Reisterstown, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

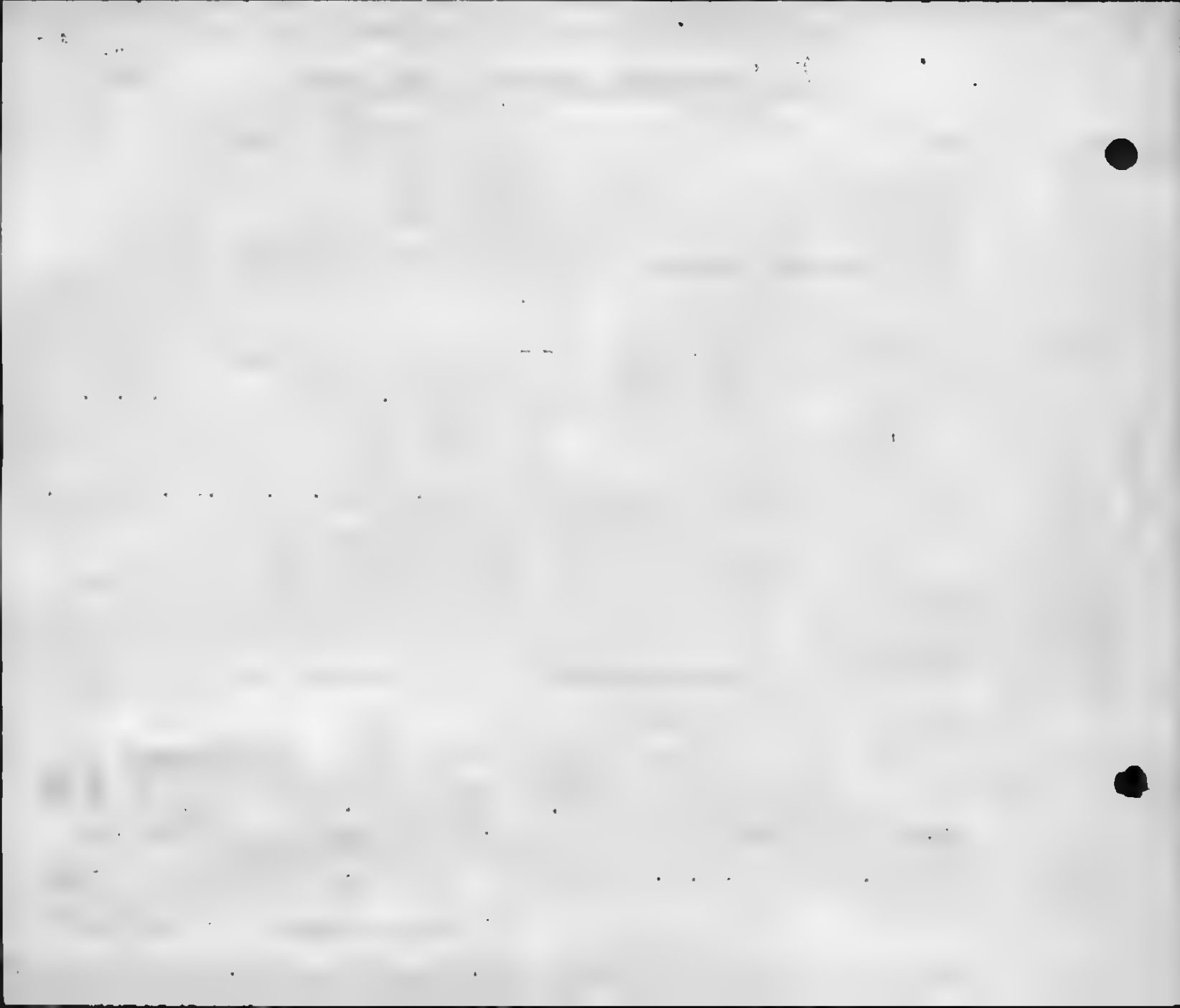
9516

CERTIFICATE OF DEATH

09511

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (If this place) <u>53 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		<u>2-10-</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1833 West Street</u>			
3. NAME OF DECEASED (Type or Print) <u>JEREMIAH O'BRIEN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 30 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>10-9-88</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Parts</u>		11. BIRTHPLACE (State or foreign country) <u>Kanturk Co. Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mullane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or detos of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>097-03-3572</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC ANEURYSM OF PROXIMAL AORTA</u>							
2. ANTECEDENT CAUSE(S) <u>XXXXX WITH SEVERE RELATIVE INSUFFICIENCY OF AORTIC</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>VALVE</u>						<u>UNKNOWN</u>	
4. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 7, 1955</u> , to <u>Oct. 30, 1955</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10-31-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Long Island National</u>		LOCATION (City, town, or county) (State) <u>Long Island, New York</u>	
24. REC'D BY REGISTRAR <u>Nov. 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farkens</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Funeral Home, St. Paul & Preston Sts</u> <u>Baltimore, Maryland</u>			



9517

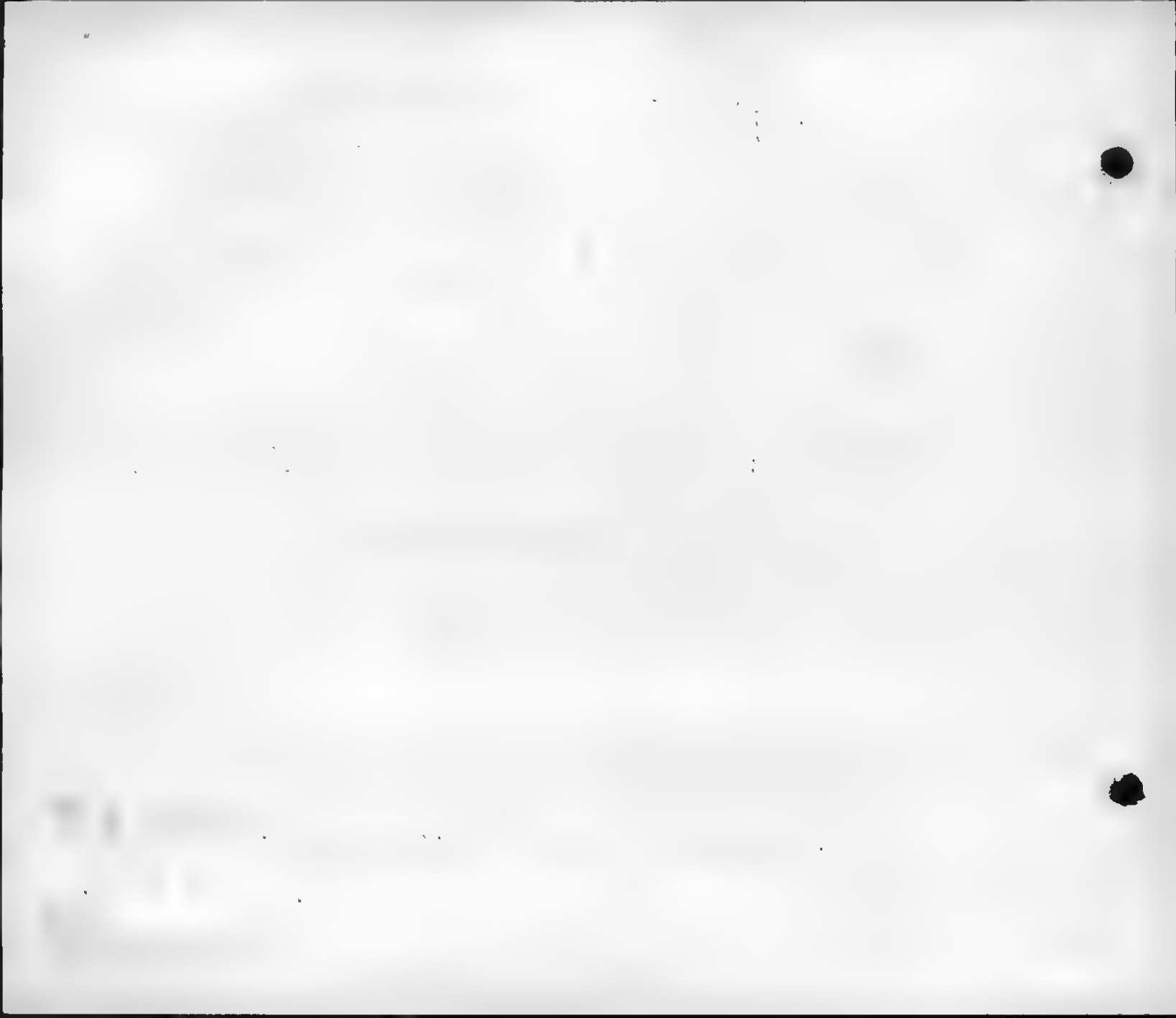
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		STATE <u>md.</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>	
TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place) <u>36 m</u>		STREET ADDRESS (If rural give location) <u>Cokeysmill Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hosp</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Condon Rhodes Orendorff</u>				<u>Oct. 20 1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 1, 1904</u>	9. AGE last birthday: <u>51</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>lumber</u>		11. BIRTHPLACE (State or foreign country): <u>Zepp, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jefferson Orendorff</u>				14. MOTHER'S MAIDEN NAME: <u>Willie Wymer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Army 219-14-6997</u>				16. SOCIAL SECURITY NO. <u>Hosp. Records, Mt. Wilson, Md.</u>			
17. INFORMANT & ADDRESS: <u>Mt. Wilson State Hosp.</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>				<u>8 years</u>			
ANTECEDENT CAUSE (B) <u>002X</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 14, 1955</u> to <u>Oct. 20, 1955</u> that I last saw the deceased alive on <u>Oct. 20, 1955</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William M. D.</u>		M. D. <u>Mt. Wilson, Md.</u>		DATE SIGNED <u>Oct 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>Zepp</u>		LOCATION (City, town, or county) (State) <u>Zepp, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 21, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>		24. FUNERAL DIRECTOR <u>C. M. Welch - Wingfield, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

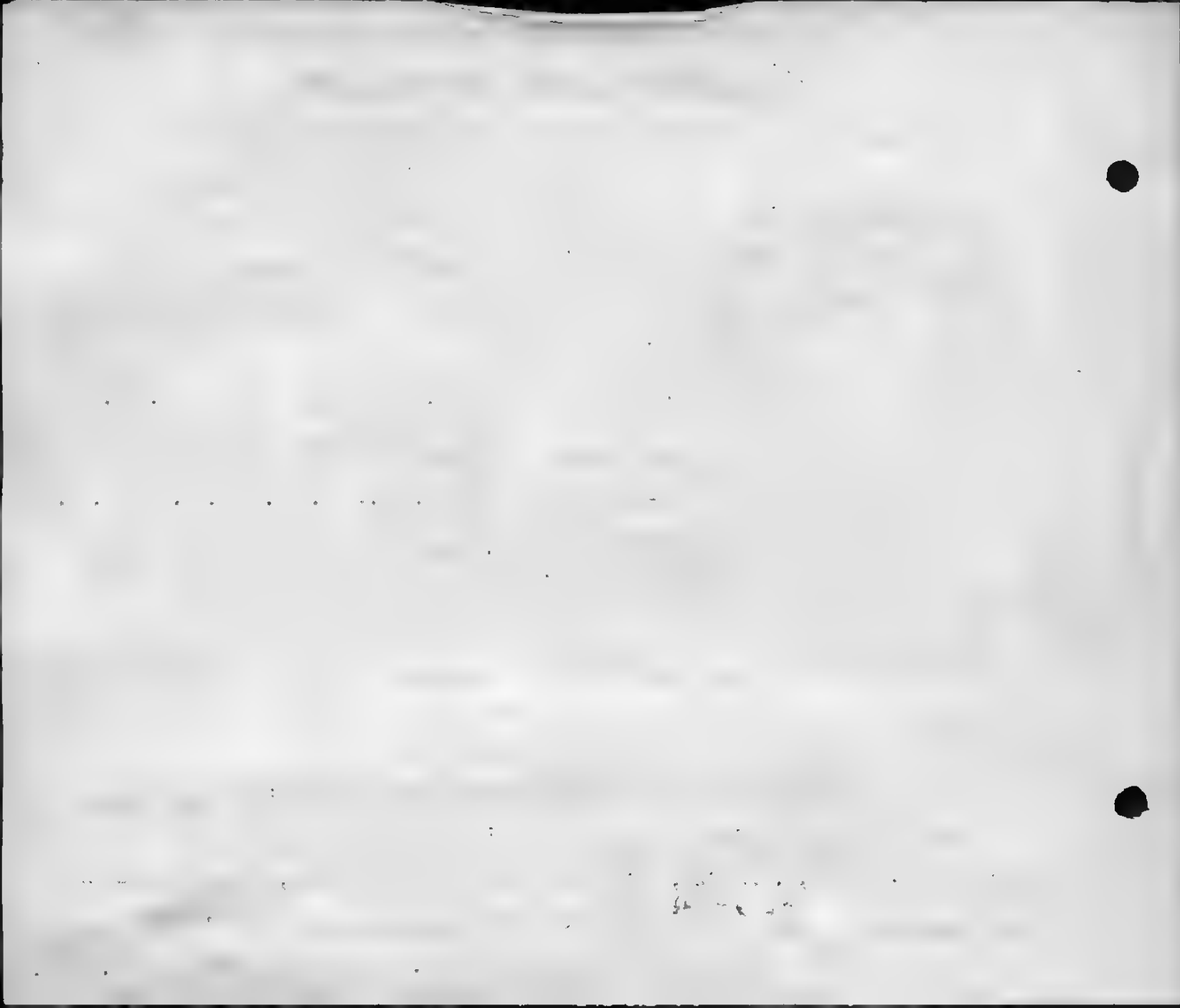
09513

9518

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>14</u> Hours		CITY OR TOWN <u>Baltimore</u>		<u>3401.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1321 West Baltimore Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ANTHONY</u> <u>PARKER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 25</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/8/17</u>	9. AGE last birthday <u>37</u> yrs.	IF UNDER 1 YEAR (Month) (Day) (Year)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Mobile, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Parker</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>211-05-3241</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
522x IMMEDIATE CAUSE (A) <u>PULMONARY EMPHYSEMA, CHRONIC</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE(S) DUE TO <u>BRONCHIECTASIS, CHRONIC</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>COR PULMONALE</u>						<u>UNKNOWN</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> <u>6:00 PM</u> <u>8:00 AM</u> attended the deceased from <u>October 24, 1955</u> to <u>October 25, 19 55</u> , and that death occurred at <u>8:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>F. S. Dickey MD.</u>				ADDRESS (Street, city, town, state) <u>FORT HOWARD MARYLAND</u>			
DATE THEREOF <u>Oct. 28/55</u>				DATE SIGNED <u>10-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>			
24. REC'D BY REGISTRAR <u>Oct. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave. Balto. Md.</u>	



9392

CERTIFICATE OF DEATH

Reg. Dist. No. *4*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Relay</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Relay</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1536 Rolling Rd</u>				STREET ADDRESS <u>1536 Rolling Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Elizabeth K. Patterson</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>10-19-55</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>		8. DATE OF BIRTH: <u>Jan. 15, 1861</u>	
				9. AGE last birthday: <u>94</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Hamilton Riall</u>				14. MOTHER'S MAIDEN NAME: <u>Rose Kelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Helen McHale, 1538 Rolling Rd.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
457.0 Immediate cause (a) <u>Generalized Arteriosclerosis</u> DUE TO						Unknown	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>DUE TO</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) (If INJURY		INJURY OCCURRED While at Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>49</u> , to <u>Oct. 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 17</u> , 19 <u>55</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John J. Gura</u>				(DEGREE OR TITLE) <u>M. D.</u>		ADDRESS <u>1 Willow Hill Ave., Baltimore, Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Par</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE RECD BY LOCAL REG. <u>10/22/55</u>				REGISTRAR'S SIGNATURE <u>Gen. Keaffer</u>		24. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 A 000

MARYLAND

STATE DEPARTMENT OF HEALTH

9519

CERTIFICATE OF DEATH

Reg. Dist. No. 33

Item 8, Film G188 10-28-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore</u>		STREET ADDRESS <u>1124</u>	
3. NAME OF DECEASED (Type or Print) <u>MARGARET ELIZABETH PENSEL</u>		4. DATE OF DEATH (Month) <u>11</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/21/1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>443X</u> Immediate cause (a) <u>Cerebral</u>				<u>1 day</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>11/21/11</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10/22/55, 1955, to 11/19/55, that I last saw the deceased alive on 11/17/55, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>10/22/55</u>	<u>Woodlawn Cem.</u>	<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>10-22-55</u>		<u>Wm. J. Dickner & Sons - Balto., Md.</u>		<u>17, Md.</u>	

MARGIN RESERVED FOR BINDING



9520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FORT HOWARD</u>		<u>3 DAYS</u>		TOWN <u>BALTIMORE</u>		<u>3V-1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>237 N. GILMORE STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>RONIOUS (NM) PERRY</u>				<u>DEATH: OCTOBER 1 19 55</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>COLORED</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>DIVORCED</u>		8. DATE OF BIRTH: <u>7/18/10</u>	
9. AGE last birthday: <u>45</u> yrs.		Months		Days		Hours	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>CONTRACTOR WORK</u>		11. BIRTHPLACE (State or foreign country): <u>WALSTONBURG, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>EDD PERRY</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE WILLIAMS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>YES</u> <u>WW-II</u>				16. SOCIAL SECURITY NO. <u>244 16 5913</u>			
17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND</u>							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA</u>						<u>10 DAYS</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>PANCREATITIS, ACUTE SECONDARY TO ABOVE</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT 28, 19 55</u> to <u>OCT. 1, 19 55</u> and that death occurred at <u>10:10M.</u> from the causes and on the date stated above.							
A. ADDRESS				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				24. FUNERAL DIRECTOR			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)			
<u>10/3-55</u>		<u>Charles R. Law</u>		<u>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</u>			
25. ADDRESS				26. ADDRESS			
<u>802 MADISON AVE. BALTIMORE, MD.</u>							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

09517

2411 N. Charles Street, Baltimore

9521

CERTIFICATE OF DEATH

Reg. Dist. No. 31

Item 9, Film 188 11-1-55 et

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rockdale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>3533 Wild Cherry Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert</u> (First) <u>Pincher</u> (Middle) <u>Pincher</u> (Last)		4. DATE OF DEATH <u>Oct 24</u> (Month) <u>1955</u> (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Apr 21, 1868</u>
9. AGE last birthday <u>92</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>England</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mason</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>William R. Pincher</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
Immediate cause <u>140X</u> <u>Pneumonia of left lung</u>		
Antecedent cause(s) <u>-</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>-</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c) <u>-</u>		
19a. DATE OF OPERATION <u>11-1-55</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1955, to Oct 24, 1955, that I last saw the deceased alive on Oct 23, 1955, and that death occurred at 12:05 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10-26-55</u>	<u>Woodlawn</u>	<u>Baltimore Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>10/25/55</u>	<u>W. H. Hedrick</u>	<u>Forrest Byron</u>	<u>5005 Park Ave Baltimore 15, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6222

9522

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:

COUNTY **BALTIMORE**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) **PORT HOWARD**

LENGTH OF STAY (In this place) **101 DAYS**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **VETERANS ADMINISTRATION HOSPITAL**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **PENNSYLVANIA** COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) **PHILADELPHIA**

OR TOWN **PHILADELPHIA**

STREET ADDRESS (If rural give location) **1939 ELSTON STREET**

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

JOHN

(NMI)

PINKERTON

5. SEX:

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3. NAME OF DECEASED:

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3. NAME OF DECEASED:

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3. NAME OF DECEASED:

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(Middle)

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(NMI)

PINKERTON

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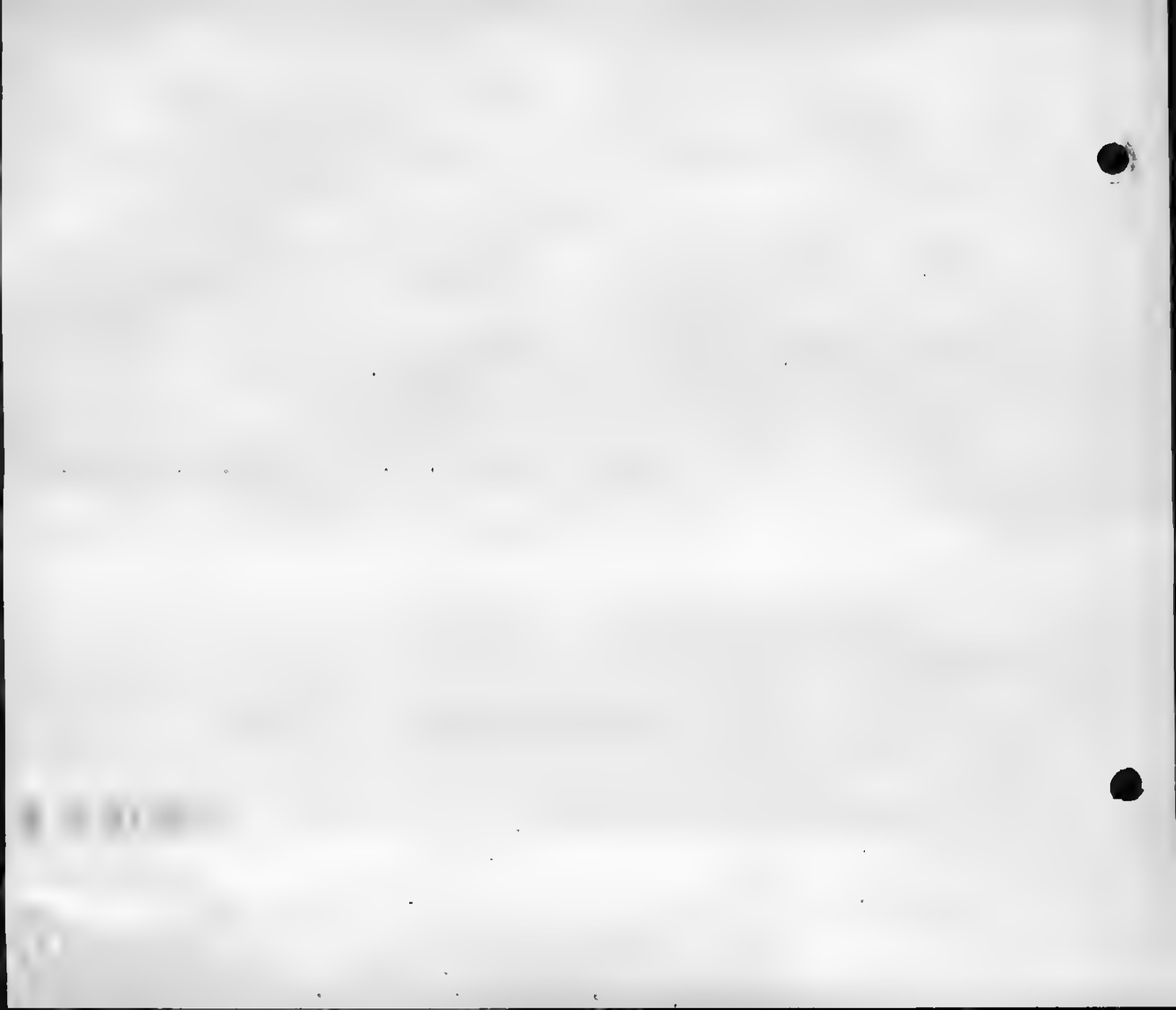
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9523

CERTIFICATE OF DEATH

Reg. Dist. No.

53

1. PLACE OF DEATH: Sheppard-Pratt Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

COUNTY Baltimore

MARYLAND

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Towson

LENGTH OF STAY (in this place)

TOWN Baltimore

34.1.7

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard and Enoc Pratt

STREET ADDRESS (If rural give location)

HOSPITAL Hospital

2602 Elsinore Ave. - 16

3. NAME OF DECEASED: (First) Lillian (Middle) May (Last) PITTS (Type or Print)

4. DATE OF DEATH: (Month) October (Day) 22 (Year) 1955

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct. 6, 1871

9. AGE last birthday: 84 yrs. 17 UNDER 1 YEAR 17 UNDER 24 MRS. Months: Days: Hours: Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME:

James T. Mitchell

14. MOTHER'S MAIDEN NAME:

Grace Baldwin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

45.1 Immediate cause

(a) Cerebral thrombosis DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Generalized arteriosclerosis and chronic myocarditis. DUE TO

(c)

Interval Between Onset And Death

1 month

4 years plus

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senile psychosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY I

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 10, 1951, to Oct. 22, 1955, that I last saw the deceased

alive on Oct. 21, 1955, and that death occurred at 3:30 a.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

M. Elgin, M.D.

Asst. Med. Supt.

Sheppard-Pratt Hosp.

10/22/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

10/25/55

Green Mount Cem.

Balto., Md.

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10/24/55

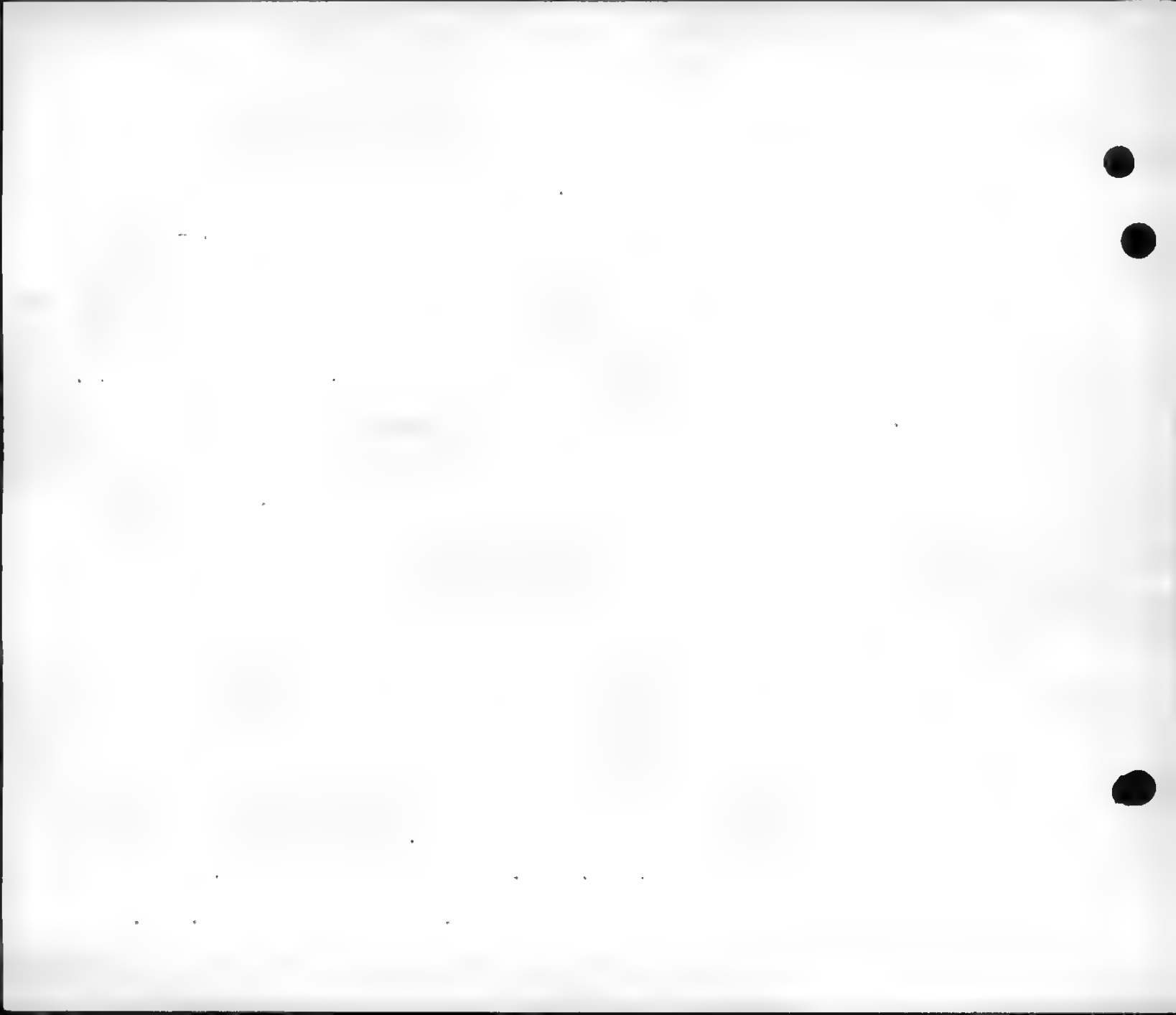
A. W. Hadlock

Thos. J. Fickner & Sons

Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9524

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09520

Reg. Dist.

No. 13

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>FULLERTON</u>		<u>40 yrs</u>		TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>292 Ridge Pt.</u>				STREET ADDRESS (If rural, give location) <u>184 292 Ridge Road</u>			
3. NAME OF DECEASED: (First) <u>Amelia</u> (Middle) <u>Prescoe</u> (Last) <u>Prescoe</u>				4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct 12/1876</u>		9. AGE last birthday: <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u> (Hours) <u></u> (Min.) <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ind.</u>	
13. FATHER'S NAME: <u>Henry Prescop</u>				14. MOTHER'S MAIDEN NAME: <u>Mary (Anderson)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u></u> (If Yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Laura Johnson (sister)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause		(a) <u>Coronary occlusion</u>					
Antecedent cause(s)		(b) <u>Cor. Vascular Disease</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) <u></u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
21d. TIME (Month) (Day) (Year) (Hour) OF DEATH <u>Oct 3 5.58 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>William M.D.</u>		M. D.		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>10-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>ARBORETUM M.E.M. PK</u>		LOCATION (City, town, or county) <u>ARBORETUM, MD</u>	
DATE REC'D BY LOCAL REG. <u>6-55</u>		REGISTRAR'S SIGNATURE <u>John H. ...</u>		24. FUNERAL DIRECTOR <u>Joseph ...</u>		ADDRESS <u>1304 N. ...</u>	

MARGIN RESERVED FOR BINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09521

9525

CERTIFICATE OF DEATH

Reg. Dist. No. 17

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Ma.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Cockeysville</u>		<u>life</u>		STREET ADDRESS (If rural give location)		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sherwood Road.</u>				STREET ADDRESS <u>Sherwood Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>George Edward Price</u>				OF DEATH: <u>Oct. 18</u> 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>August 5, 1914</u>	<u>71</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Labourer</u>		<u>Farming</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Price</u>				<u>McBroom</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>none</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>daughter; Mrs. Mary Howard, Cockeysville</u>				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				4 hrs.			
IMMEDIATE CAUSE				7 yrs.			
ANTECEDENT CAUSE (S)				"			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Acute pulmonary edema</u>							
(B) <u>Con pulmonary</u>							
(C) <u>Chronic bronchiectasis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22 I hereby certify that I attended the deceased from <u>1950</u> , to <u>Oct. 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 18</u> , 19 <u>55</u> , and that death occurred at <u>5 A.</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Elizabeth B. Shumilt</u>				<u>Cockeysville, Md.</u>		<u>10/18/55</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Buried</u>				<u>10-21-55</u>		<u>Jessops Methodist</u>	
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
				<u>Wm. J. Whitcraft</u>		<u>Brookland Funeral Service, Sparks, Md.</u>	

U.S. AIR FORCE

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH

09522

9526

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Lochearn		CITY (If outside corporate limits, write RURAL and give nearest town) Lochearn	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3700 Oak Ave.		STREET ADDRESS (If rural, give location) 3700 Oak Ave.	
3. NAME OF DECEASED (First) George (Middle) Lucius (Last) Price		4. DATE OF DEATH (Month) October (Day) 6 (Year) 1955	
5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH August 15, 1891 9. AGE (last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Buffalo, New York	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank S. Price		14. MOTHER'S MAIDEN NAME Louise Simmons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I		16. SOCIAL SECURITY NO. 317-05-5045	
17. INFORMANT AND ADDRESS Mrs. Louise Whitworth, 321 72nd St. Newport News Va.		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Obstructive jaundice

INTERVAL BETWEEN ONSET AND DEATH

1 wks.

Antecedent cause(s)

(b)

Cause unknown.**1 wks.**

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

None.**None.**

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY **None.**INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

None.

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, and that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

D. D. Caples Deputy Med. Exam. M. D.**Reisterstown, Md.****10-7-55**

23. CREMATION (If so, specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial**October 9, 1955 Knoll Kreg****Abingdon, Virginia**

24. FILED BY LOCAL REG.

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Oct 7, 1955**Harvey G. Murrell****Frank H. Murrell Parkersville, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



09523

MARYLAND

STATE DEPARTMENT OF HEALTH

9527

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Reddick</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7407 Brightside Avenue		STREET ADDRESS (If rural, give location) 7407 Brightside Avenue	
3. NAME OF DECEASED (Type or Print) Mr. William Jackson		4. DATE OF DEATH (Month) (Day) (Year) October 10th 1955	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 1, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter - Prop. S. L. Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 62 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Tye River, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Thomas Jackson Proffitt		14. MOTHER'S MAIDEN NAME Laura Litchford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 231-03-9707	
17. INFORMANT AND ADDRESS Mrs. Myrtle S. Proffitt, 7407 Brightside Av			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
416X Immediate cause (a)..... Chronic Rheumatic Heart Disease				12 yrs +	
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11 -, 1943, to 10 - 10 -, 1955, that I last saw the deceased alive on 10 - 10 -, 1955, and that death occurred at 9:05 P.m., from the causes and on the date stated above.

SIGNATURE *N. J. Dainoff* ADDRESS *3218 Eastern ave* DATE SIGNED *Bottom 24 ml*

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE Oct. 13 1955	NAME OF CEMETERY OR CREMATORY <i>Harford Mem PK</i>	LOCATION (City, town, or county) <i>Balto. Md</i>	(State)
DATE REC'D BY LOCAL REG. <i>10-11-55</i>		REGISTRAR'S SIGNATURE <i>U. L. Hedrich</i>		24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road #14	

MARGIN RESERVED FOR BINDING

Dr. Davidou
3218 Eastern Ave.
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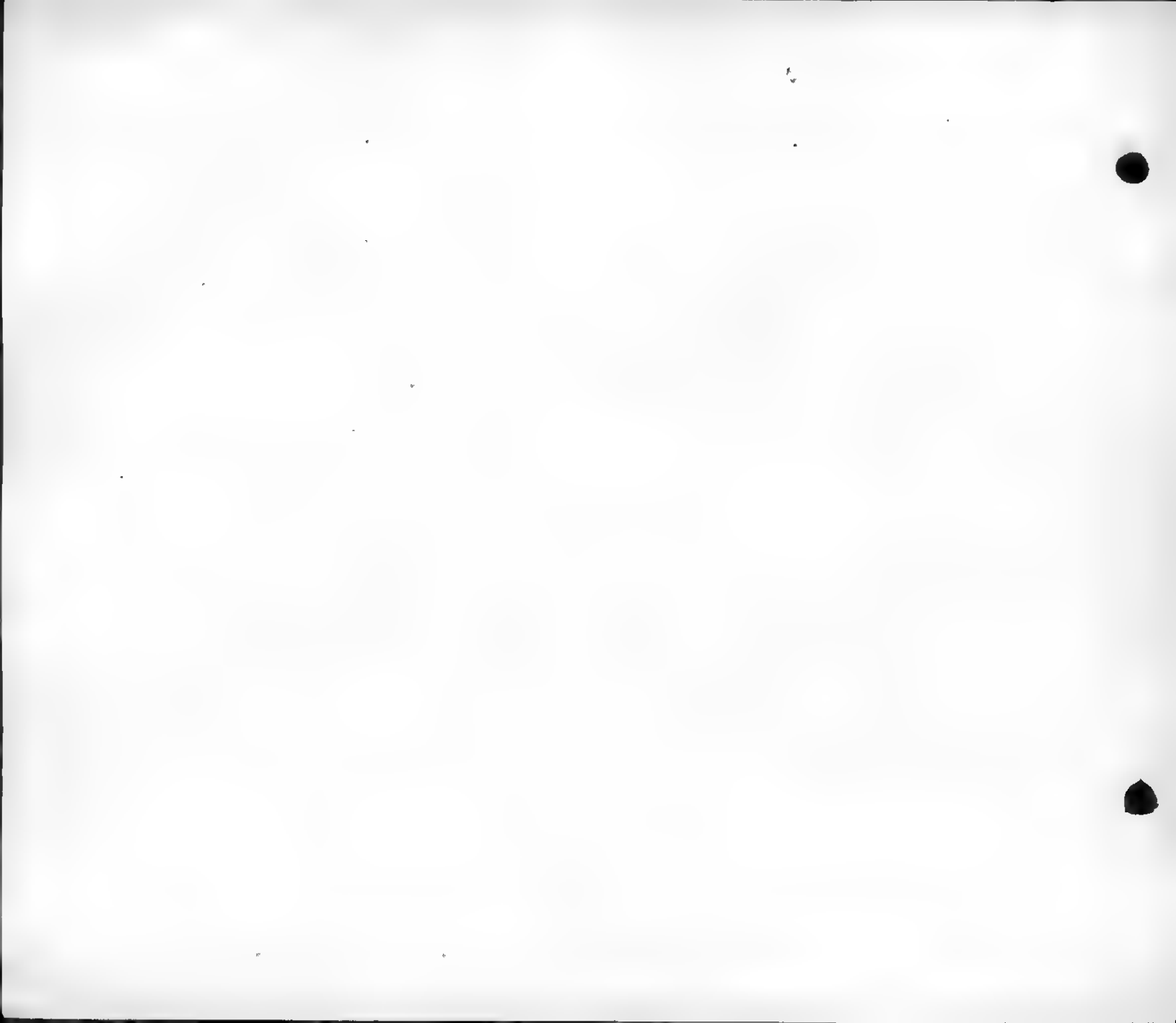
CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Balto.		STATE		Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		COUNTY		A. A.	
52 TOWN		Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Gambrill	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Wayne Convalescent Home				St. Stephens Rd.			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
MAMIE		C,		REDDIN		Oct. 7, 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH	
female		white		widowed		Dec. 7, 1879	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
75 yrs.		homemaker		Md.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Thomas M. Green				Sarah A. Hooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no							
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
Mrs. O. D. Howe - Glen Burnie, Md.				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. DATE OF OPERATION:			
450.0				19B. MAJOR FINDINGS OF OPERATION			
IMMEDIATE CAUSE (A)				Generalized Arteriosclerosis			
ANTECEDENT CAUSE (B)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST				DUE TO			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				53 7 Oct 55			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 7 Oct 1955, and that death occurred at 2:05 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
J. H. Math A.D.				8 Oct 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF			
Burial				10/10/55			
NAME OF CEMETERY OR CREMATORY				LOCATION (City, town, or county) (State)			
Green Mount Cem.				Balto., Md.			
DATE REC'D BY LOCAL REGISTRAR				24. FUNERAL DIRECTOR			
REGISTRAR'S SIGNATURE				ADDRESS			
J. H. Math				Wm J. Vickner & Sons, Balto 17 Md.			

MARGIN RESERVED FOR BINDING



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09525

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Mass</u>	COUNTY <u>58</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
51 TOWN <u>Acushnet</u>	<u>5 days</u>	TOWN <u>Springfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>5378 Thomas an</u>		<u>16 Roosevelt an</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>William</u>	(Middle) <u>J</u>	(Last) <u>Reid</u>	(Month) <u>Oct</u> (Day) <u>20</u> (Year) <u>1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 9 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if changed)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday: <u>59</u> yrs.
<u>Cable splicer</u>		<u>Telephones</u>	IF UNDER 1 YEAR: Months Days Hours Min.
13. FATHER'S NAME: <u>William J Reid</u>		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
16. SOCIAL SECURITY No.:		14. MOTHER'S MAIDEN NAME: <u>Mary Castle</u>	
17. INFORMANT & ADDRESS: <u>Mrs Betty Reid 16 Roosevelt an Springfield Ma</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>47.0.1</u> Immediate cause (a)..... <u>Cornary thrombosis</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Dr. McKieffer</u>	1610 Leedmore	CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct 20, 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>	DATE THEREOF <u>Oct 20, 55</u>	NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem</u>
LOCATION (City, town, or county) (State) <u>Springfield Mass</u>	24. FUNERAL DIRECTOR <u>Harry H. Britz</u>	ADDRESS <u>4101</u>
DATE REC'D BY LOCAL REG <u>Oct 20 55</u>	REGISTRAR'S SIGNATURE <u>Dr. McKieffer</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09526

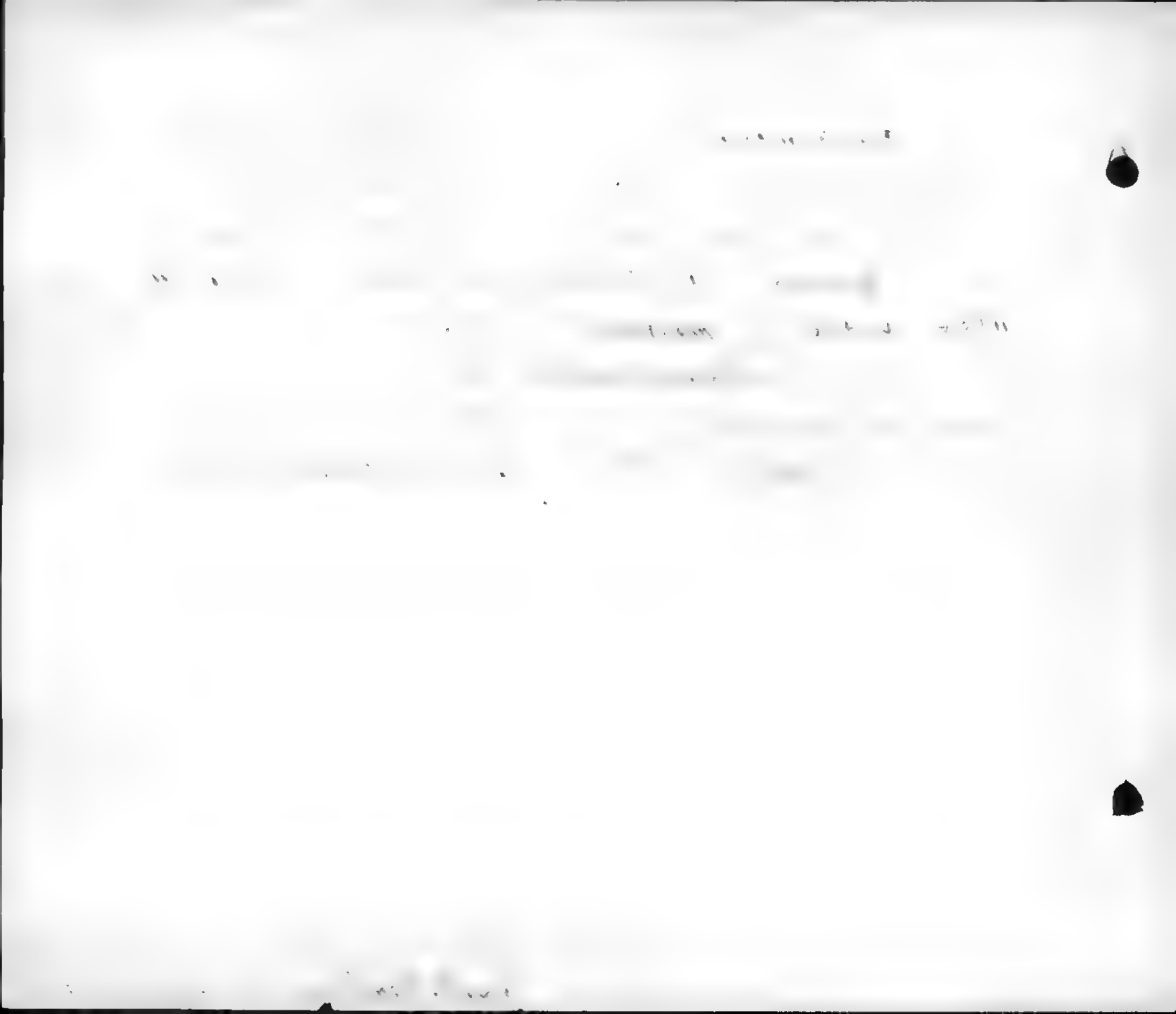
9394

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 LANSDOWNE</u>		LENGTH OF STAY (In this place) <u>20YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LANSDOWNE</u>		<u>51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>301 FOURTH AVE.</u>				STREET ADDRESS (If rural give location) <u>301 FOURTH AVE</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>GEORGE</u>		(Middle) <u>P.</u>		(Last) <u>REINHARDT SR.</u>		DATE: <u>OCT. 4</u> 19 <u>55</u>	
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>DEC. 12, 1898</u>	
9. AGE last birthday: <u>56</u> yrs.		10. AGE last birthday: <u>56</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired): <u>POSTAL CLERK RAILWAY EXPRESS.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>RAILWAY EXPRESS.</u>			
13. FATHER'S NAME: <u>JACOB H. REINHARDT</u>				14. MOTHER'S MAIDEN NAME: <u>MARY E. STRASSER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>EDITH M. REINHARDT 301 FOURTH AVE</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						<u>10 minutes</u>	
ANTECEDENT CAUSE (B) <u>Essential Hypertension</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Sclerosis</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>Nov 1945</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Bilateral Sympathectomy for Essential Hypertension</u>			
20. AUTOPSY? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1955</u> to <u>Oct 4, 1955</u> that I last saw the deceased alive on <u>Sept 6, 1955</u> and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Earl Pass, M.D.</u>				DATE SIGNED <u>10-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10-7-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-6-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Joseph [Signature]</u>		ADDRESS <u>1324 Dolphin St. Bal.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u>		LENGTH OF STAY (in this place) <u>3 mos. 15 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 19</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>2111 Anna Avenue</u> /			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna Reisinger</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>October 30, 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>7-21-1883</u>	
				9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Germany</u>	
13. FATHER'S NAME: <u>August Powering</u>				14. MOTHER'S MAIDEN NAME: <u>Dorothy Toulke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							
ANTECEDENT CAUSE (B) <u>Pyonephrosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Nephrolithiasis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-15-</u> , 19 <u>55</u> , to <u>10-30-</u> , 19 <u>55</u> that I last saw the deceased alive on <u>10-30-</u> , 19 <u>55</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Spella Wachler</u>				DATE SIGNED <u>10-31-55</u> M. D. <u>Spring Grove State Hospital</u> <u>Catonsville 28, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		ADDRESS <u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>			



9530

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Parkville

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

3009 Acton Road.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Baltimore

STREET ADDRESS

(If rural give location)

3203 Leaverton Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

CHARLESRESCH

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Oct. 17, 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleWhiteWidowedApril 12, 187184

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)

Wagon driver

10b. KIND OF BUSINESS OR INDUSTRY:

Brewery

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Michael Resch

14. MOTHER'S MAIDEN NAME:

Don't know

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Miss Rose Resch 3203 Leaverton Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

199.9
Immediate cause(a) Carcinomatous thrombosis
DUE TO or origin undetermined - metastaticAntecedent causes (s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) to live
DUE TO obstruction of arteries(c) Calculus, Malnutrition, Hemiparesis

Interval Between Onset And Death

6 Mos.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

Generalized arteriosclerosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

1955, to Oct 17, 1955, that I last saw the deceasedalive on 20th 15, 1955, and that death occurred at 6:45 AM

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

10-18-55Dr. H. H. H. H. H.Ullrich Funeral Home 4210 Belair Road,

MARGIN RESERVED FOR INDEXING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



9531

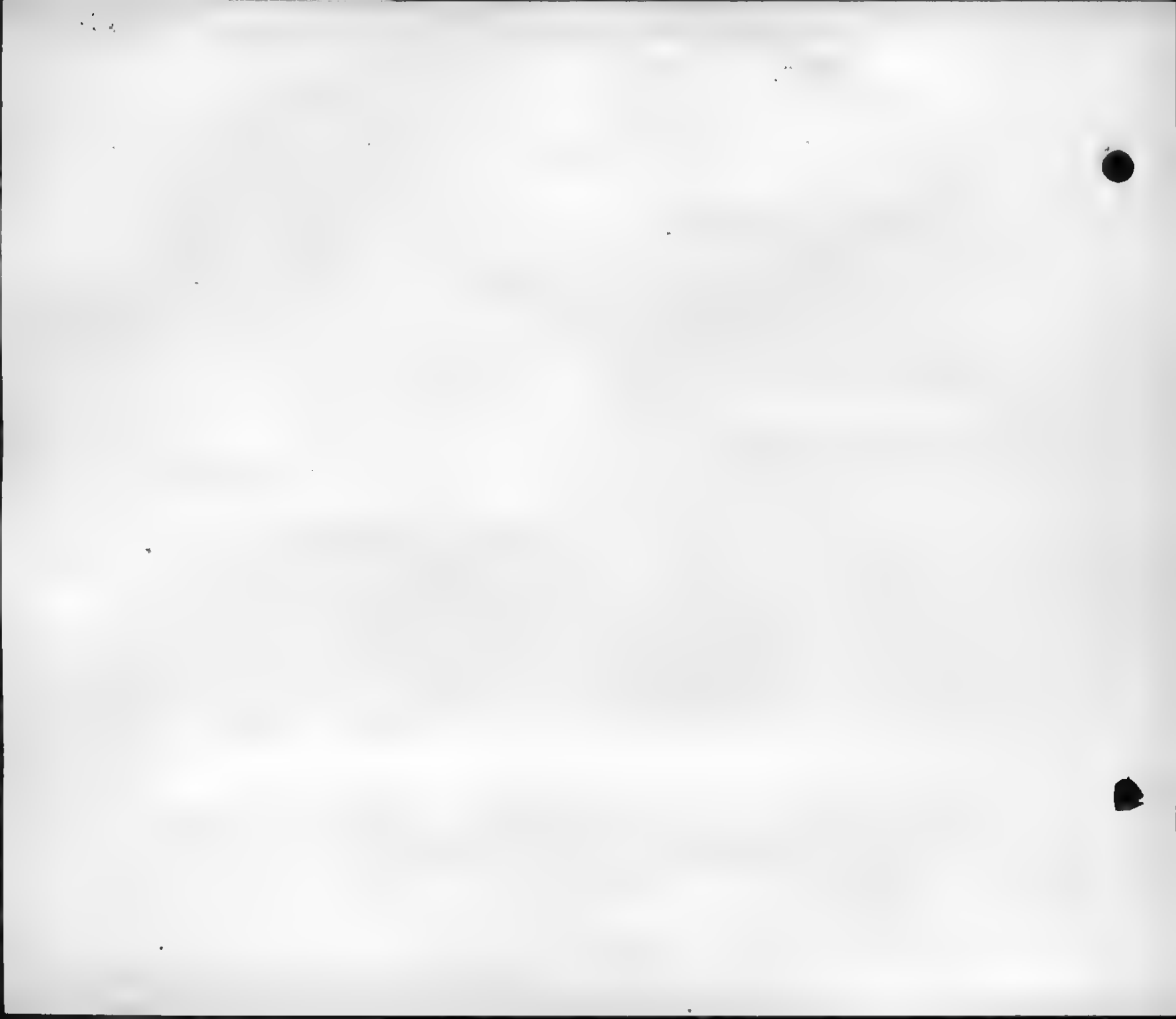
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Anneslie</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Anneslie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 Murdock Rd.</u>				STREET ADDRESS (If rural give location) <u>515 Murdock Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>PAULINE M. RICHARDSON</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 12, 1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>diowed</u>	8. DATE OF BIRTH: <u>Aug. 14, 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lewis B. Eyler</u>				14. MOTHER'S MAIDEN NAME: <u>Mary S. Eyler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Ethel E. Coster - 515 Murdock Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>154X Terminal bronchopneumonia</u>						<u>1 da.</u>	
ANTECEDENT CAUSE (8) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST						<u>1 wk.</u>	
(A) <u>Artemia</u>						<u>3 mos.</u>	
(B) <u>Acute pyelonephritis</u>							
(C) <u>Recurrent carcinoma of rectum</u>						<u>2 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma of rectum removed 5 yrs. ago.</u>							
19A. DATE OF OPERATION: <u>July 1950</u>		19B. MAJOR FINDINGS OF OPERATION <u>Carcinoma of rectum, removed.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 1950, to <u>Oct. 12</u> , 1955, that I last saw the deceased alive on <u>July 12</u> , 1955, and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Doct. B. Shigley M.D.</u>		M. D. <u>Maxwell A. Bly</u>		DATE SIGNED <u>10/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/4/55</u>		REGISTRAR'S SIGNATURE <u>Wm. Richard [illegible]</u>		24. FUNERAL DIRECTOR <u>Wm. J. [illegible]</u>		ADDRESS <u>17 [illegible]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



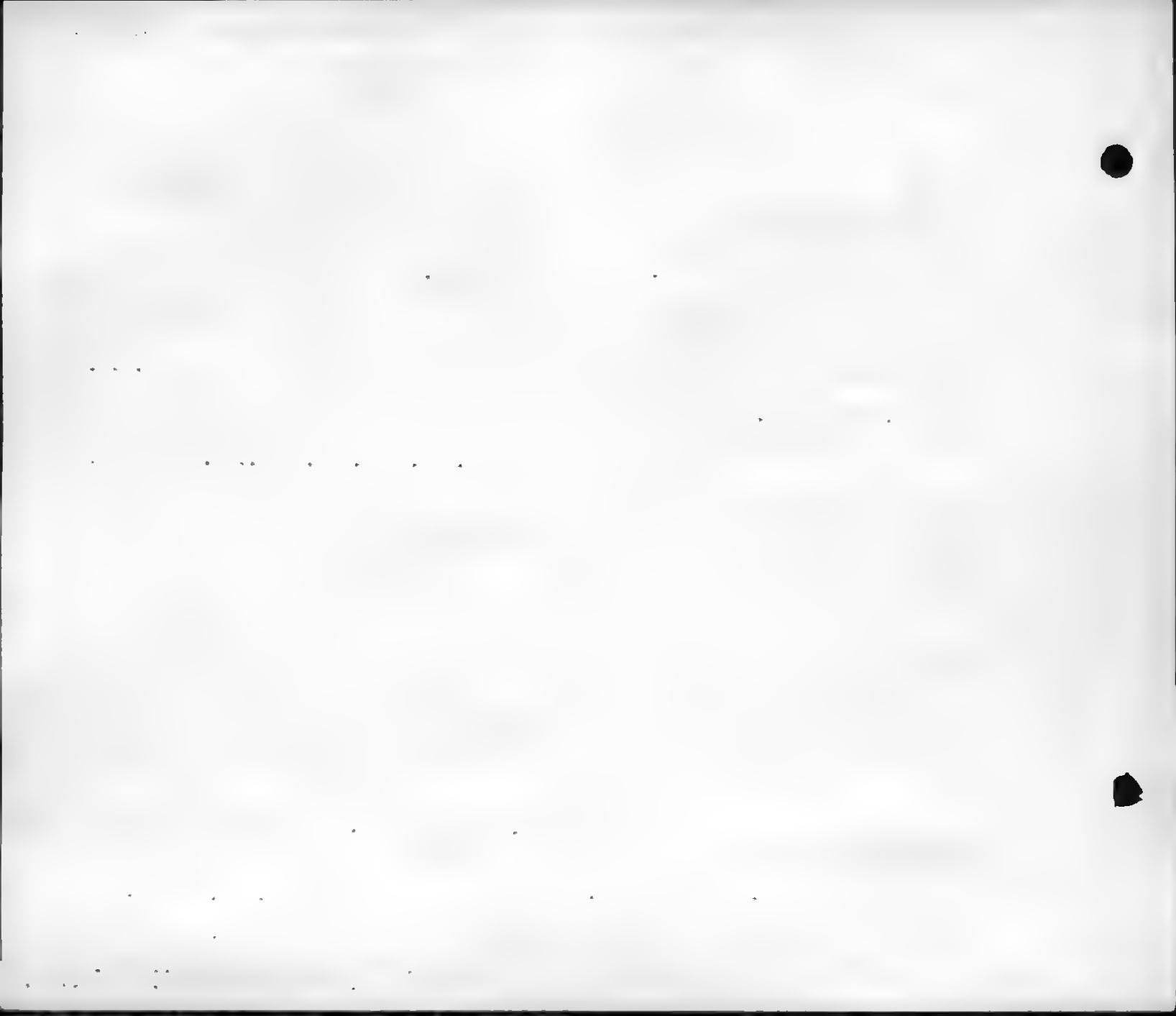
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **09530**
9532 **CERTIFICATE OF DEATH** Reg. Dist. No. **41**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN FORT HOWARD		18 Days		TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 1531 Lochwood Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
ADOLPH H. RIDER Jr.				October 8 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday, yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	MARRIED	12-1-96	58	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Clerk		Engineering Company		New Orleans, Louisiana		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Adolph H. Rider, Sr.				Edna Raiford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Yes		216-07-5285		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A)		RESPIRATORY FAILURE			
ANTECEDENT CAUSE (S)		DUE TO		BRONCHOGENIC CARCINOMA		2 MONTHS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)					
		DUE TO					
		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 20, 1955 to Oct. 8, 1955 , and that death occurred at 11:23 PM , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
WINSTON C. DUDLEY, M. D.		VAH, Fort Howard, Md.		10-9-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/11/55		Druid Ridge Cemetery		Pikesville, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-70-55		✓		Henry W. Jenkins and Sons Co., Inc.		4905 York Rd. at Rossiter Ave., Balto., Md.	

MARGIN RESERVED FOR BINNING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4 9533

09531

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>BALTIMORE</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town) OR	
TOWN <u>Jones Creek</u>		TOWN <u>BALTIMORE (Jones Creek)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7338 WALDMAN AVE</u>		STREET ADDRESS (If rural, give location) <u>7338 WALDMAN AVE</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>RAYMOND</u>	(Middle) <u>CHARLES</u>	(Last) <u>RIFE</u>	(Month) <u>10</u> (Day) <u>29</u> (Year) <u>1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>10-2-55</u>
9. AGE last birthday: <u>—</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>ARTHUR T. RIFE</u>		14. MOTHER'S MAIDEN NAME: <u>CHARLIE V. SHRIVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>A.T. RIFE - Same</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Constitutional Heart disease (probably due to)</u>			<u>27 days</u>
Antecedent cause(s) (b) <u>Leukemia of Fallopian</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>None</u>			
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Jack O. Collins</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURLAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>10-31-55</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Oct. 31-55</u>		24. FUNERAL DIRECTOR <u>Samuel L. Zerkow</u> ADDRESS <u>1401</u>	

TWO FOR ONE CERTIFICATE
FIRM 6188 - 11/7/55 - Mnt.

9534

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MIDDLE RIVER</u>			
TOWN <u>RIDERWOOD</u>		<u>Six days</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SOERENSON RUXWAY NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>2 BLINKER COURT</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>MINNIE</u> <u>RIFFLE</u>				<u>Oct 27</u> <u>22</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>FEMALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>FEB. 28, 1901</u>	<u>54</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>		<u>OWN HOME</u>		<u>W. VIRGINIA</u>		<u>USA</u>	
13. FATHER'S NAME: <u>THOMAS MC CORD</u>				14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>NONE</u>		<u>FAMILY RECORDS</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>metastasis of Carcinoma.</u>							<u>day & night</u>
ANTECEDENT CAUSE (S) DUE TO <u>malignancy face and neck.</u>							<u>3 years</u>
DUE TO <u>Basal Carcinomatosis.</u>							<u>1 year.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY?
<u>none</u>		<u>no operation.</u>					YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<u>no accident</u>		<u>M.</u>		<u>no injury.</u>			
22. I hereby certify that I attended the deceased from <u>Oct 17, 1955</u> , to <u>Oct 22, 1955</u> , that I last saw the deceased alive on <u>Oct. 20, 1955</u> , and that death occurred at <u>1040 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James Graham Harrison</u>				ADDRESS <u>M. O. 516 Cathedral St</u>		DATE SIGNED <u>October 25, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Oct. 26, 1955</u>		<u>Maple Chapel Cem.</u>		<u>Timonium, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 26, 1955</u>		<u>Mabel C. Gray</u>		<u>John Burner's Sons, Towson, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

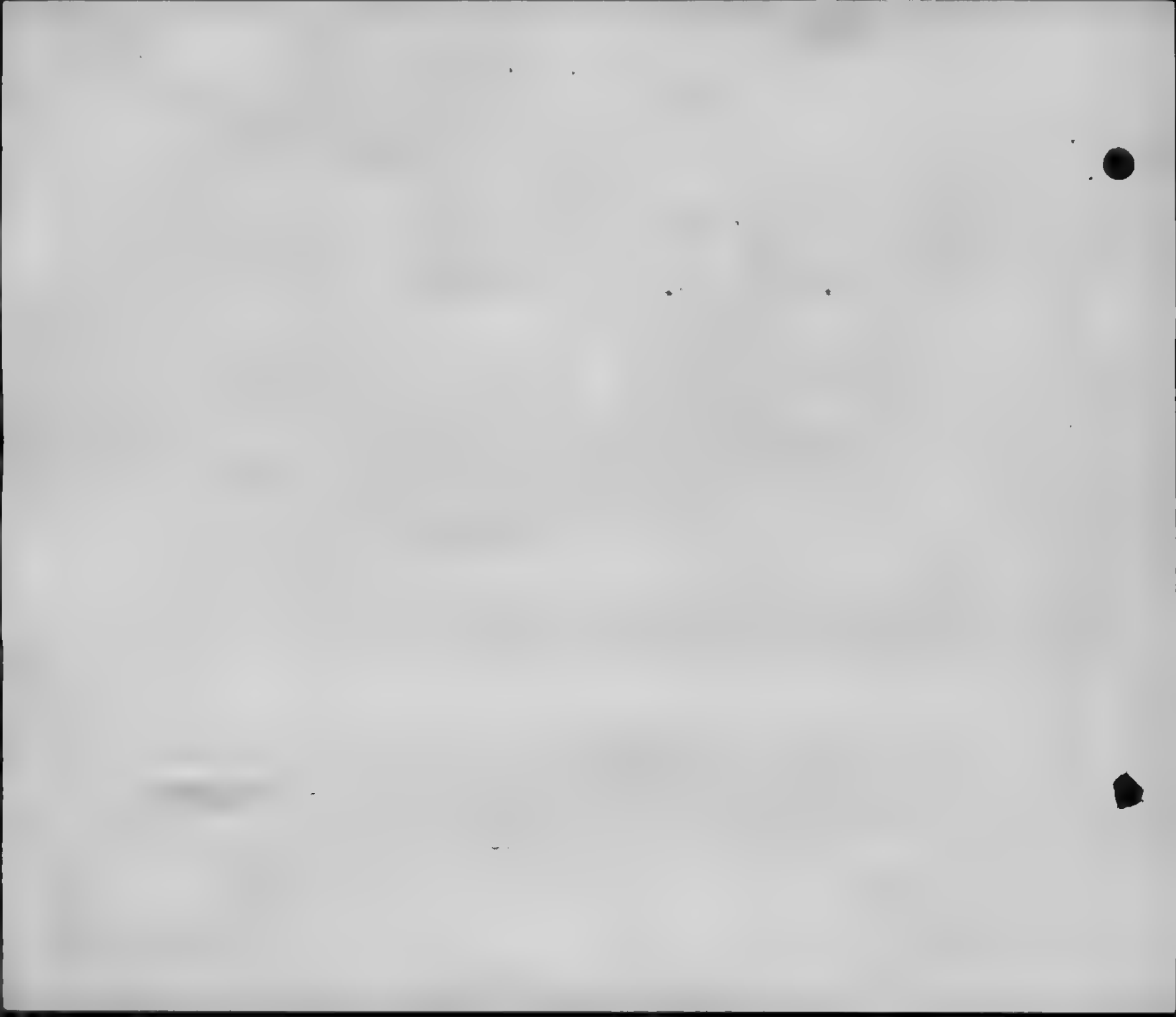
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5/1/00

No.

INTERVAL BETWEEN ONSET AND DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Former Residence 3603 - Chodale Ave
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

9535

CERTIFICATE OF DEATH

09534

Reg. Dist. No. 32

Item 9, Film 188 10-26-55 et

1. PLACE OF BIRTH COUNTY <u>Registo</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>20</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkessville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkessville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allysbury Home</u>		STREET ADDRESS <u>6811 Chesapeake Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret M. Roemer</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH Jan 1, 1871 78 Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Weyland C. Stoll</u>		14. MOTHER'S MAIDEN NAME <u>Anna B. Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Records Allysbury Home</u>	
17. INFORMANT AND ADDRESS <u>Records Allysbury Home</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4 Immediate cause	(a) <u>Cerebral Hemorrhage</u>	<u>3 wks.</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerosis - Sclerotic Heart Disease</u>	<u>- 2 yrs.</u>
(c) <u>Generalized Arteriosclerosis</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8/12, 1954, to 10/9, 1955, that I last saw the deceased alive on 10/6, 1955, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>Paul L. Chambers</u>	(Degree or title) <u>Dr. D</u>	ADDRESS <u>4108 Liberty Hts Balto - 7-Inf</u>	DATE SIGNED <u>10-11-55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>3-11-55</u>	NAME OF CEMETERY OR CREMATORY <u>Union Burial</u>	LOCATION (City, town, or county) (State) <u>Balto - 7-Inf</u>
DATE REC'D BY LOCAL REG. <u>10-11-55</u>	REGISTRAR'S SIGNATURE <u>C. G.</u>	24. FUNERAL DIRECTOR <u>Edw. J. Smith</u>	ADDRESS <u>6067 Traywood Rd</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09535

Item 14, Filed 19 11-16-55 et

9536

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>—</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
TOWN <u>PIKESVILLE</u>		TOWN <u>BALTIMORE</u>	<u>32</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<u>100 Old Cour X Road</u>		<u>3563 FAIRFIELD Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Philip ALVIN ROPPEL</u>		DATE OF DEATH: <u>10-25-1955</u>	
5. SEX:	6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday
<u>MALE</u>	<u>WHITE</u>	<u>7-4-1903</u>	<u>52</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>TAVERN OWNER</u>		<u>TAVERN</u>	<u>BALTIMORE, Md.</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>FRED ROPPLE</u>		<u>Elizabeth Fiddler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>52-055-2783</u>	

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE		
(A) <u>Chronic myocarditis</u>		<u>1 month.</u>
ANTECEDENT CAUSE (S)		
(B) <u>Hypertension</u>		<u>1 yr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19th, 1955, to Oct 25th, 1955, that I last saw the deceased alive on Oct 25th, 1955, and that death occurred at 9:35 P. M, from the causes and on the date stated above.

SIGNATURE <u>James G. Miller, Jr.</u>	ADDRESS <u>Pikesville - P.M.D.</u>	DATE SIGNED <u>10/26/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>	<u>10/28/55</u>	<u>Druid Ridge</u>
LOCATION (City, town, or county) (State)		
<u>PIKESVILLE, Md</u>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>10/29/55</u>	<u>Harold A. Ruff</u>	ADDRESS
		<u>Frank H. Ruff, Pikesville, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9537

Item 9: funeral director's correction 10-10-55L **CERTIFICATE OF DEATH**

Reg. Dist. No. 34

1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STREET
OR and give nearest town) (in this place)
TOWN FAIRMONT

HOSPITAL OR THE SORESENSEN NURSING HOME
INSTITUTION OR
STREET ADDRESS 7912 RUXWAY ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE MARYLAND COUNTY 2
CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN BALTIMORE CITY

STREET ADDRESS (If rural give location)
347 ILLCHESTER AVE.

3. NAME OF DECEASED:

(First) (Middle) (Last)
NATHAN EDWARD RUTLEDGE

4. DATE OF DEATH: (Month) (Day) (Year)
OCT. 2 1955

5. SEX:

MALE

6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

WIDOWED

8. DATE OF BIRTH:

FEB. 7, 1862

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS

92 yrs. 8 Months 2 Days 2 Hours 1 Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life.

MILLWRIGHT

10b. KIND OF BUSINESS OR INDUSTRY:

WOOD MILL

11. BIRTHPLACE (State or foreign country).

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

WILLIAM RUTLEDGE

14. MOTHER'S MAIDEN NAME:

ELIZA SILK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: MRS. VERA RITZMAN HIGHVIEW AVE 6804

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) myocardial Hypertrophy with Failure

Interval Between Onset And Death

10 years

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Chronic myocarditis.

10 years

(c) General Arteriosclerosis

10 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Hernitical Hernia.

10 years

19a. DATE OF OPERATION:

none

19b. MAJOR FINDINGS OF OPERATION

no operation.

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT

(Specify)

SUICIDE

PLACE (Home, farm, factory, street, office bldg., etc.)

INJURY

(CITY OR TOWN)

no

(COUNTY)

no

(STATE)

no

TIME (Month) (Day) (Year) (Hour)

OF INJURY no

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

no

22. I hereby certify that I attended the deceased from 9-14-1955, to 10-2-1955, that I last saw the deceased

alive on 9-27, 1955, and that death occurred at 12.30 P.M. from the causes and on the date stated above.

SIGNATURE

James Graham Manton MD

(Degree or title)

ADDRESS

516 Cathedral St

DATE SIGNED

10-4-1955

23. BURIAL, CREMATION, or other disposal (Specify)

BURIAL

DATE THEREOF

OCT. 5, 1955

NAME OF CEMETERY OR CREMATORY

WEST LIBERTY CHURCH CEMETERY (METHODIST)

LOCATION (City, town, or county)

Farmington

(State)

MD

DATE REC'D BY LOCAL REGISTRAR

10-5-55

REGISTRAR'S SIGNATURE

L.

24. FUNERAL DIRECTOR

Henry H. Johnston

ADDRESS

4905 York Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

5/6 C + medium AT

9538

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
TOWN <u>Pikesville</u>		TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Irving Place</u>		STREET ADDRESS (If rural give location) <u>6 Irving Place</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>PETER A. SCHEMES</u>		DATE OF DEATH: <u>Oct. 16</u> 1955	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 1st. 1881</u>
9. AGE last birthday <u>74</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Bernard Schmedes</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Gotlben</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes W.W.#1</u>		16. SOCIAL SECURITY No. <u>213-20-8743</u>	
17. INFORMANT & ADDRESS: <u>Marie E. Schmedes, Wife, 6 Irving &</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>		<u>30 months</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary artery arteriosclerosis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis generalized</u>		<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>—</u> , 19 <u>—</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Lucien D. Adams</u> M.D.		ADDRESS <u>Pikesville 8 Md</u> DATE SIGNED <u>10/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/16/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>October 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Norothy G. Newell</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell - Pikesville (C), Md.</u>		ADDRESS <u>—</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6. 1. 1961

2. 1. 1961



3. 1. 1961



09538

MARYLAND

9539

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Balto	
CITY (If outside corporate limits, write RURAL and give nearest town) Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3015 Woodside Avenue		STREET ADDRESS (If rural, give location) 3015 Woodside Avenue	
3. NAME OF DECEASED (First) Mrs. Bertha (Middle) May (Last) Schrufer		4. DATE OF DEATH (Month) Oct. (Day) 2nd (Year) 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4/1/1889
9. AGE last birthday 66 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Crosby		14. MOTHER'S MAIDEN NAME Emma Schauermann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Louis Schrufer, 3015 Woodside Avenue #11			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a)..... Cerebral Hemorrhage			
Antecedent cause(s) (b)..... Hypertension & V. Disease			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)..... Arteriosclerosis			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 8, 1950, to Oct. 2, 1955, that I last saw the deceased alive on 10/1, 1955, and that death occurred at 11:50 P. m., from the causes and on the date stated above.			
SIGNATURE Nathan Janney MD		ADDRESS 7101 Harford Rd. Balto. Md. 10/3/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 10/5/1955	
NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) Baltimore, Maryland	
DATE REC'D BY LOCAL REG. 10/5/55		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14		ADDRESS	

MARGIN RESERVED FOR BINDING

Dr. Janney
7101 Harford Road
9 and 10

Please call us when Ready HA 6 1460

9540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY

BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

X TOWN RURAL-VILLANOVA

LENGTH OF STAY (in this place)

4 MONTHS

HOSPITAL OR INSTITUTION OR STREET ADDRESS

90 KATHERINE ROBB NURSING HOME 4105 ESSEX Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MARYLAND

COUNTY

BALTIMORE

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN BALTIMORE

30.14

STREET ADDRESS (If rural give location)

922 WILLOWOOD PARKWAY

3. NAME OF DECEASED:

(First)

VIRGINIA

(Middle)

(Last)

SEVIER

4. DATE (Month) (Day) (Year)

DEATH: 10

17

1953

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

WIDOWED

8. DATE OF BIRTH:

Unk. Abt. 1866

9. AGE last birthday

Abt. 89 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

HOUSEWIFE

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Robert O. Elliott

14. MOTHER'S MAIDEN NAME:

Mary E. Bean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS:

C. Maurice Weidmeyer, Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442 X

IMMEDIATE CAUSE

(A)

UREMIA

DUE TO

ANTECEDENT CAUSE (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B)

Hypertension C.V. RENAL DISEASE - Antecedent 8 YEARS.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

7 days

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(Country)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May... 1915 to OCT. 17, 1953, that I last saw the deceased

alive on OCT. 17, 1953, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

SIGNATURE

Edward G. Purpura

ADDRESS

M.D. 8204 LIBERTY RD BALTO. 2, MD. 10/17/53

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Oct. 20, 1955

NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

LOCATION (City, town, or county)

Baltimore, Maryland.

DATE REC'D BY LOCAL REGISTRAR

10-17-53

REGISTRAR'S SIGNATURE

E. G. Purpura

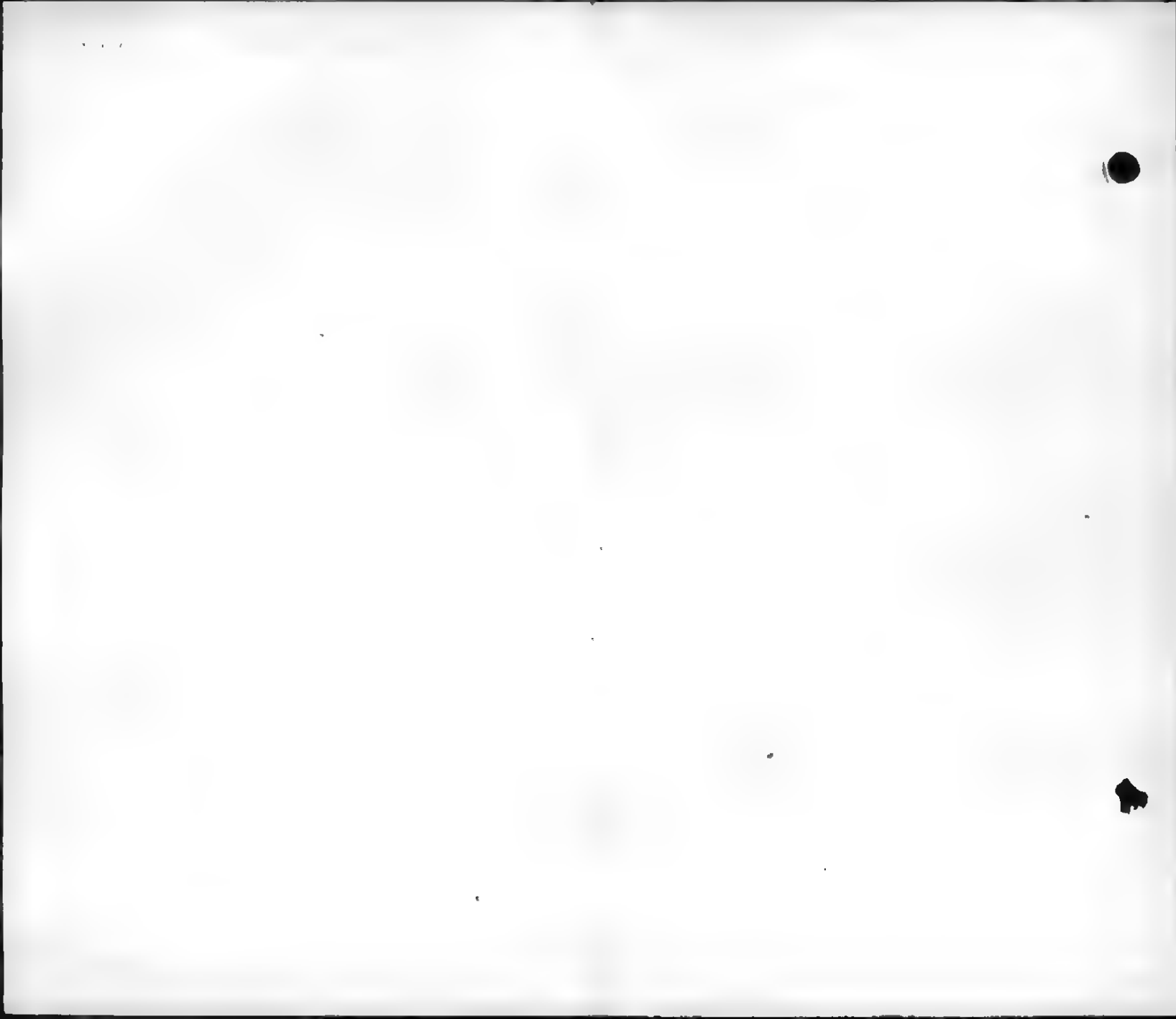
24. FUNERAL DIRECTOR

E. G. Purpura

ADDRESS

4510 Liberty Hgts. Avenue

MARGIN RESERVED FOR BINDING



09540

MARYLAND

9541

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Whitmarsh</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Whitmarsh</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RED LION ROAD Box 1009</u>		STREET ADDRESS (If rural, give location) <u>Red Lion Road Box 1009</u>	
3. NAME OF DECEASED (Type or Print) <u>William GREEN Sheppard</u>		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>27</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. STATUS <u>WIDOWED, DIVORCED</u> (Specify)	8. DATE OF BIRTH <u>Nov. 27, 1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Store - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>	9. AGE last birthday <u>93</u> yrs. If under 1 year: Months: Days: If under 24 hrs. Min.
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN Sheppard</u>		14. MOTHER'S MAIDEN NAME <u>Martha - UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Flora Edna Dolan Bel Air Md Rte 3 Box 44</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>42</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
Immediate cause (a) <u>Coronary Thrombosis</u>					
Antecedent cause(s) (b) <u>Bronchial Pneumonia</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Cardio-Vascular disease</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 1</u> , 19 <u>55</u> , to <u>Oct 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>55</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>William Gardner M.D.</u>		ADDRESS <u>Baltimore</u>		DATE SIGNED <u>10/27/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Oct 30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Zion</u>	
LOCATION (City, town, or county) (State) <u>Fountain Bluff Md</u>		24. FUNERAL DIRECTOR <u>Joseph J. Fisher</u>		ADDRESS <u>Bel Air Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

State Dept. of Health
2411 McCharles St

9542

CERTIFICATE OF DEATH

Reg. Dist. No. 40

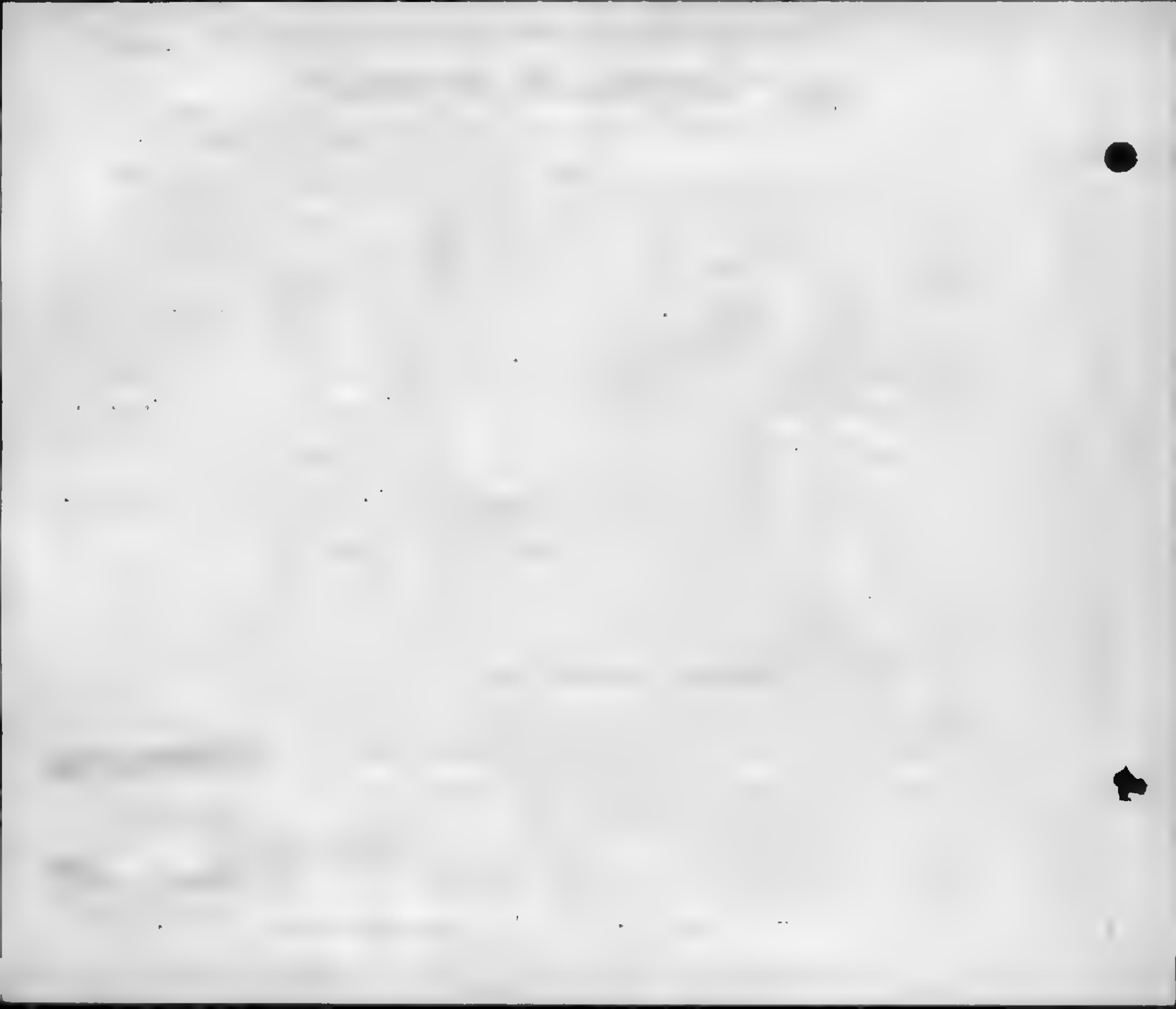
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Whitemarsh</u>		20 Years		TOWN <u>Whitemarsh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1017 Red Lion Road</u>				STREET ADDRESS (If rural give location) <u>1017 Red Lion Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>E.</u> (Last) <u>Simpson</u>				(Month) <u>10</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Aug. 21, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Watchman-Retired</u>		<u>Distillery</u>		<u>Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard Simpson</u>				<u>Sarah McMahon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>212-01-4880A</u>		<u>Frieda R. Simpson-1017 Red Lion Rd.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arteriosclerosis, Coronary Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>7-20</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1st</u> , 19 <u>40</u> , to <u>Oct 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>53</u> , and that death occurred at <u>3:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James J. White M.D.</u>				ADDRESS (Street, city, town, state) <u>422 Eastern Ave Baltimore 21, Md</u>			
DATE SIGNED <u>10/29/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-29-55</u>		<u>St. Michael's</u>		<u>Perry Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Dr. Walter Hammett</u>		<u>Sarahin Funeral Home - 7401 Belair Rd</u>			
DATE							

INSTRUCTIONS:

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



9543

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Owings Mills</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>2919 E. Federal Street</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Training School</u>				STREET ADDRESS (If rural give location) <u>Baltimore, Maryland</u>			
3. NAME OF DECEASED: (First) <u>Michael</u>		(Middle) <u>Joseph</u>		(Last) <u>Sinclair</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>19</u> <u>55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>6/14/55</u>	9. AGE last birthday <u>4</u> yrs	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>--</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Ferdinand Sinclair</u>				14. MOTHER'S MAIDEN NAME: <u>Helen Constance Mallon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No. <u>--</u>		17. INFORMANT & ADDRESS: <u>Rosewood Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
751X IMMEDIATE CAUSE (A) <u>Pneumonia, Bilateral</u>						2 days	
ANTECEDENT CAUSE (B) <u>Acute Bronchitis</u>						3 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Hydrocephalic, meningocele (Arnold Chiari Syndrome)</u>						birth	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/17</u> , 19 <u>55</u> to <u>10/19</u> , 19 <u>55</u> that I last saw the deceased alive on <u>10/19</u> , 19 <u>55</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Harry B. Butler M.D.</u> ADDRESS <u>Owings Mills, Md</u> DATE SIGNED <u>19 Oct. 55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10-20-55</u>		<u>Baltimore National</u>		<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 21, 1955</u>		<u>Mary Elsie</u>		<u>White / Burke / Bradley, New York, N.Y.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-A 01/11/11

1/11/11

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 9, 12 Film 1: 11-1-55 et

CERTIFICATE OF DEATH

09543

9544

Reg. Dist. No. 44

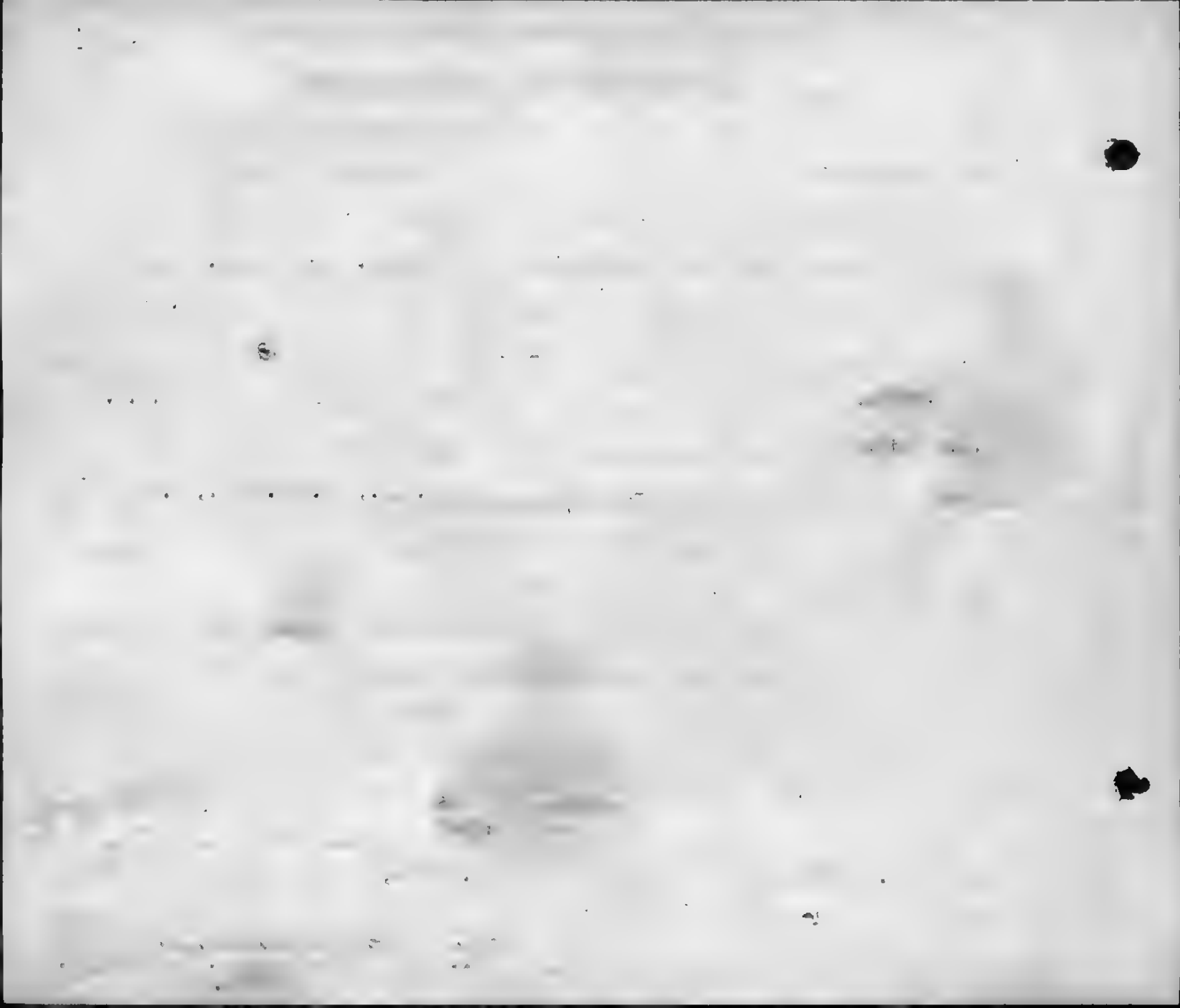
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Fort Howard</u>		<u>3 days</u>		OR TOWN <u>Baltimore</u>		<u>3V-1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>56 Veterans Administration Hospital</u>				<u>1036 W. Saratoga St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>FRANK</u> (Middle) <u>A.</u> (Last) <u>SMITH</u>				(Month) <u>October</u> (Day) <u>21</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>7-10-96</u>	<u>(59) 59</u> is.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Janitor</u>				<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Smith</u>				<u>Lucy Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>WW I</u>		<u>215-14-5076</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
521x IMMEDIATE CAUSE (A) <u>ASPHYXIA</u>						<u>SUDDEN</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ASPIRATION OF BLOOD</u>						<u>SUDDEN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>HEMORRHAGE FROM LUNG ABSCESS RIGHT LOWER LOBE</u>						<u>UNKNOWN</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
				<u>22</u>			
22. I hereby certify that I attended the deceased from <u>October 18, 19 55</u> , to <u>October 21, 19 55</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city, town, state)						DATE SIGNED	
<u>William S. VanderGriff</u>						<u>M. D. VAH Ft. Howard, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/26/55</u>		<u>Baltimore National Cemetery Baltimore, Maryland</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 28, 1955</u>		<u>Dawson L. Fackler</u>		<u>Mrs. Katie Williams</u>		<u>322 N. Schroeder St. Balto. Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The below copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

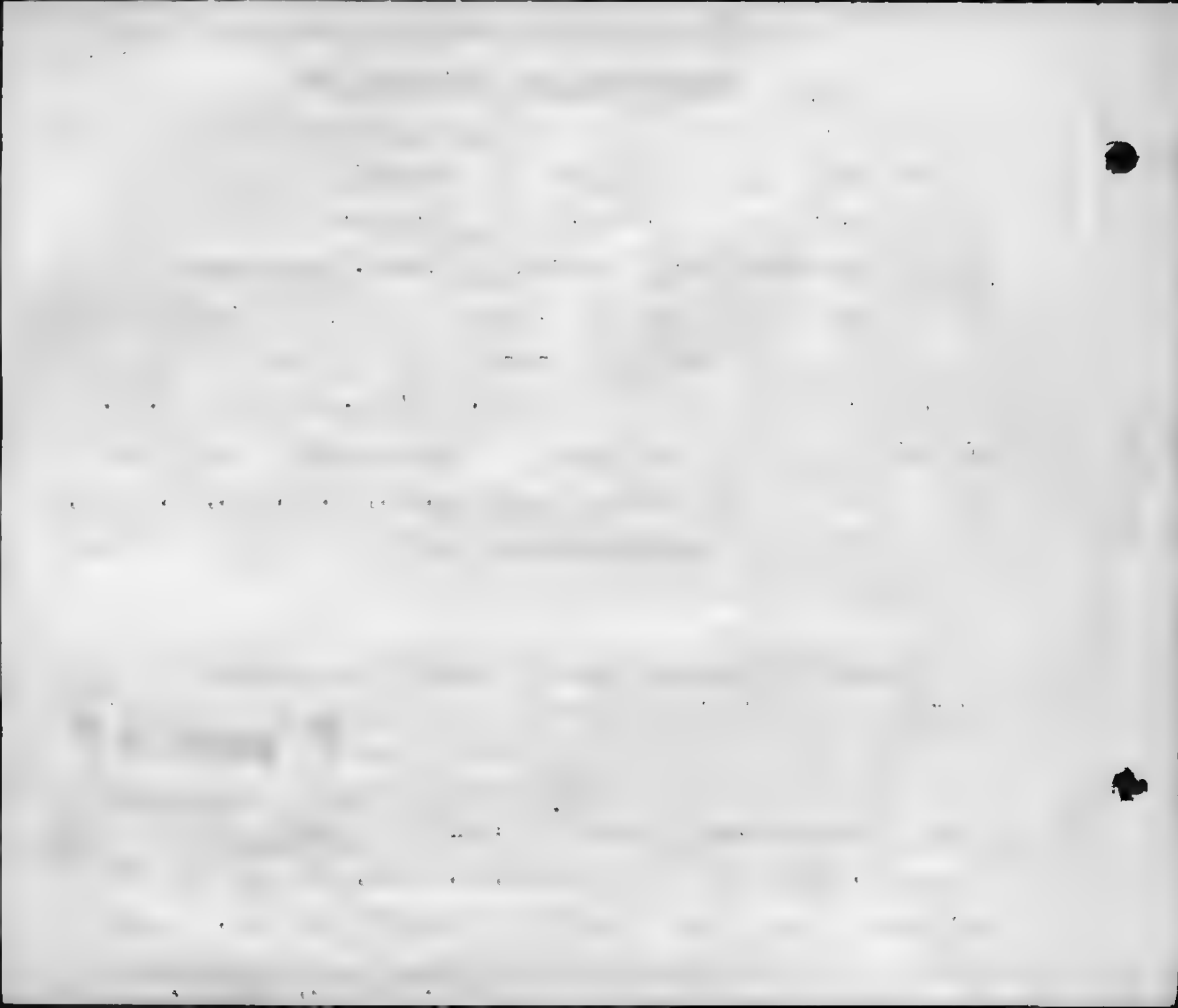
09545

9545

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>31 days</u>		TOWN <u>Baltimore</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>1921 N. Payson Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>HENRY (NMI) SMITH</u>				<u>October 22 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>1-23-89</u>	<u>66 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Janitor</u>				<u>St. Mary's Co. Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joe Smith</u>				<u>Catherine Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WW I</u>				<u>Unknown</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
157X IMMEDIATE CAUSE (A) <u>CARCINOMA OF TAIL OF PANCREAS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>10-7-55</u>		<u>Exploratory laparotomy</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>VA</u> <u>M</u>							
22. I hereby certify that I attended the deceased from <u>Sept. 21, 1955</u> , to <u>October 22 1955</u> , that he was the deceased, and that death occurred at <u>3:35 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>William B. Vandergriff</u>				<u>M.D. MAH, Ft. Howard, Md.</u>		<u>10/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/24/55</u>		<u>Baltimore National Cemetery Baltimore, Maryland</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Oct. 24, 1955</u>		<u>Lawson L. Farberg</u>		<u>Mrs. Edward Ringold</u>		<u>Mrs. Edward Ringold Funeral Home</u>	
				<u>1463 N. Carey St., Balto. Md.</u>			



1

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09546

9516

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH <i>Balto.</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Middle</i>		MARYLAND		STATE <i>Md.</i>		COUNTY	
CITY OR TOWN <i>BALTIMORE-CAT.</i>		LENGTH OF STAY <i>1 day</i>		CITY OR TOWN <i>BALTIMORE</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Richard Nursing Home</i>				STREET ADDRESS <i>306 Ingheside Ave.</i>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>KATHERINE S. SMITH</i>				4. DATE OF DEATH <i>OCT. 27 1955</i>			
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>SINGLE</i>		8. DATE OF BIRTH <i>11-27-1892</i>	
9. AGE last birthday <i>62</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BOOKKEEPER</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS B. SMITH</i>				14. MOTHER'S MAIDEN NAME <i>SALLIE E. ENGLAR</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i>		16. SOCIAL SECURITY NO. <i>278-07-7529A</i>		17. INFORMANT & ADDRESS <i>MRS. JOHN A. MASON 306 Ingheside Ave. (28)</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <i>Left ventricular failure</i>				INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>ASCVD</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Marked obesity</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>JUNE 6</i> , 19 <i>55</i> , to <i>OCT 27</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>OCT 26</i> , 19 <i>55</i> , and that death occurred at <i>4 A.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>Stephen Lee Napress</i>				ADDRESS (Street, city, town, state) <i>908 Frederick Rd, Catonsville Md 21027-51</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>10/29/55</i>		NAME OF CEMETERY OR CREMATORY <i>LODGEON PARK</i>		LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
24. REC'D BY REGISTRAR <i>Victor E. Harry</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>G. Tammann Schwaib</i>		ADDRESS <i>3512 Fred (29) Ave.</i>	
DATE							



MARYLAND STATE DEPARTMENT OF HEALTH

09547

2411 N. Charles Street, Baltimore

9547

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Balto</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 FOSTING AVENUE</u>		STREET ADDRESS (If rural give location) <u>Waldorf, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>BENJAMIN</u> (First) <u>SNEJIL</u> (Middle) <u>SNESIL</u> (Last)		4. DATE OF DEATH <u>OCT.</u> (Month) <u>16</u> (Day) <u>1955</u> (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 10, 1883</u>
9. AGE last birthday <u>72</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Muskegon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Snesil</u>		14. MOTHER'S MAIDEN NAME <u>Devora ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Waldorf, Md.</u>	
17. INFORMANT <u>Mrs. Esther Rosenstern</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
26. X Immediate cause (a) <u>Arterio Sclerotic Cardiovascular Dis.</u>		<u>5 yrs.</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Biliary Cirrhosis</u>		<u>6 months</u>
(c) <u>Distal Myelitis</u>		<u>1 yr</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct., 1953, to Oct. 16, 1955, that I last saw the deceased alive on Oct. 16, 1955, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>David E. Bogard</u>	(Degree or title) <u>MD</u>	ADDRESS <u>1905 W. Baltimore St. Bk 6</u>	DATE SIGNED <u>10/16/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Oct 18/55</u>	NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>Vol. Johnson & Bros. Inc.</u>	ADDRESS <u>1124-26 N. North Ave.</u>



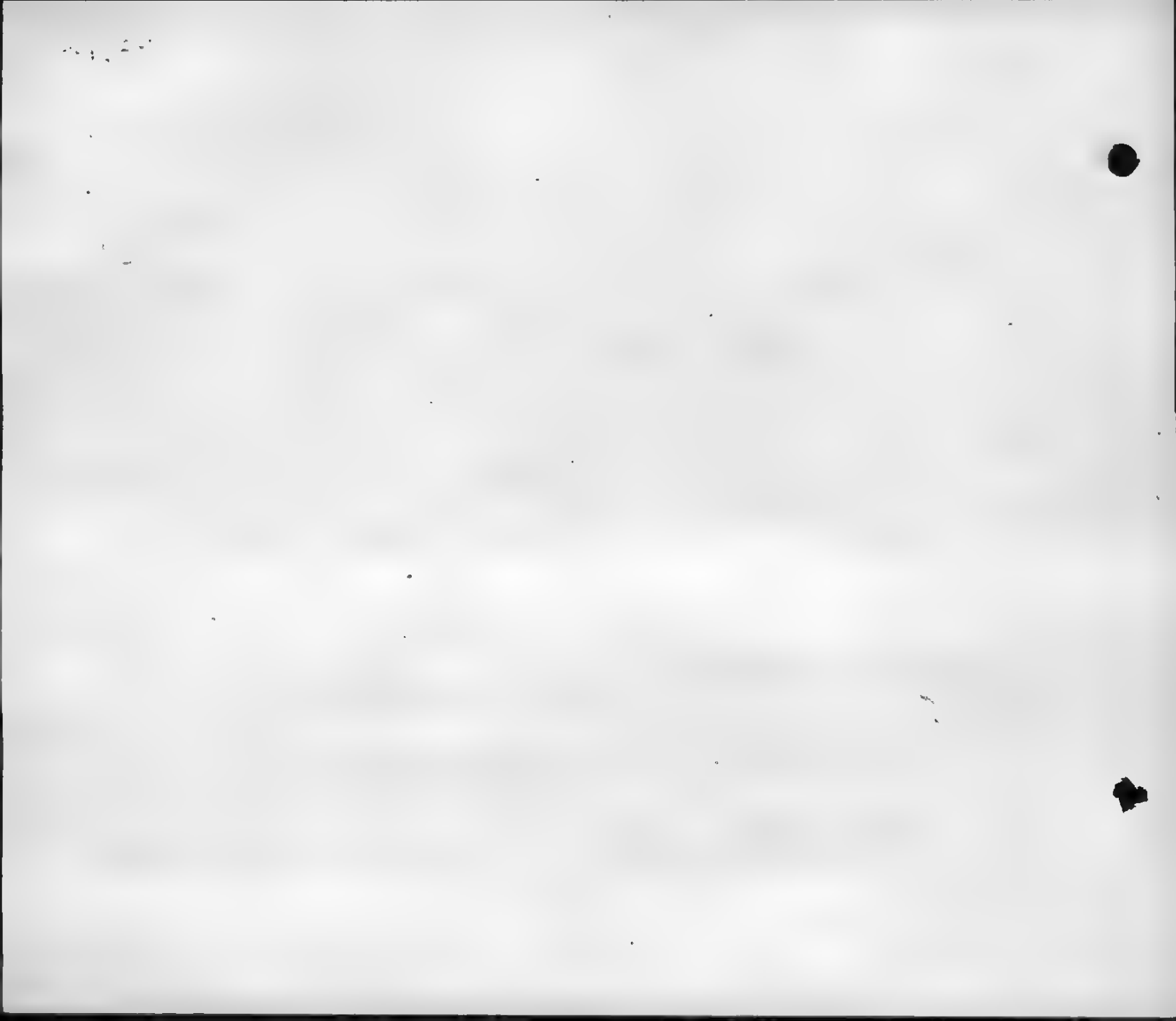
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09548
9548 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
<u>X</u> TOWN <u>Baltimore</u>	<u>10 years</u>	TOWN <u>Baltimore</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8812 Old Harford Rd.</u>		STREET ADDRESS (If rural give location) <u>8812 Old Harford Rd.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Laura Snidemiller</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>October 1 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <u>May 19, 1875</u>
9. AGE (last birthday) <u>80 yrs</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Barker</u>		14. MOTHER'S MAIDEN NAME: <u>Emily Place</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>Austin E. Richards - 8812 Old Harford Rd.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
155X IMMEDIATE CAUSE (A) <u>Co of large intestine</u>		<u>6 yrs</u>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Antineoplastic</u>	
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
22. I hereby certify that I attended the deceased from <u>12 Feb, 1955</u> , to <u>1 Oct, 1955</u> , that I last saw the deceased alive on <u>30 Sep, 1955</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Samuel L. Luper</u>		DATE SIGNED <u>16 Oct 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-4-55</u>	
NAME OF CEMETERY OR CREMATORY <u>HUNTINGTON Cem.</u>		LOCATION (City, town, or county) (State) <u>West Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>October 1st 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Wm. Cross, Inc. - 1227 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9549				09551			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
X TOWN <u>Owings Mills</u>		<u>33 yrs.</u>		TOWN <u>Baltimore</u>		<u>34</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Training School</u>				STREET ADDRESS (If rural, give location) <u>109 S. Ann Street</u>			
3. NAME OF DECEASED:		(First) <u>Adam</u>		(Middle) <u>Sobus</u>		(Last)	
(Type or Print)						4. DATE OF DEATH	
						<u>10</u> <u>24</u> <u>19</u> <u>55</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>single</u>		<u>7/31/09</u>	
						9. AGE last birthday: <u>46</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>			
13. FATHER'S NAME: <u>Michael Sobus</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Szafarz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Anna Sobus 15 S.Castle Street</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a)..... <u>Peritonitis due to perforation of ulcer in terminal ileum</u>							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
							(State)
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		<u>Paul F. Gierm</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/27/55</u>		<u>St. Stanislaus Cemetery</u>		<u>1300 Dundalk Ave-Balto, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-26-55</u>		<u>G. L. H. H. H. H.</u>		<u>George J. Weber 700 S. Ann St.</u>			



09552

MARYLAND STATE DEPARTMENT OF HEALTH

9550

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

Item 22 File 6187 10-14-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>9101</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Baltimore County Court House</u>		STREET ADDRESS (If rural, give location) <u>850 Hillman Court</u> ✓	
3. NAME OF DECEASED (First) <u>John A.</u> (Middle) <u>Soderlund</u> (Last) <u>Soderlund</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 4-1883</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year: Months <u>7</u> Days <u>1</u> Hours <u>1</u> Mins. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WATCHMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>215-01-1712</u>	
17. INFORMANT AND ADDRESS <u>Mrs Stella M. Soderlund</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4-1-1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE <u>Charles F O'Donnell Md</u>		DATE SIGNED <u>10/10/55</u>	
FEDERAL INFORMATION <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>BALTO</u>	
DATE RECEIVED BY LOCAL REG. <u>10/10/55</u>		FEDERAL DIRECTOR <u>Leonard Luck</u>	

MARGIN RESERVED FOR BINDING

THE CORRECT WAY TO WRITE WHITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

9551

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Id.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Randallstown</u>				OR TOWN <u>Randallstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Briarstone Rd.</u>				STREET ADDRESS (If rural give location) <u>Briarstone Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Henry Thomas Sorrell</u>				OF DEATH: <u>Oct. 30 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Aug. 26, 1864</u>	
				9. AGE last birthday: <u>91</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Contractor and Builder</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME: <u>Thomas Sorrell</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mary Viola Smith - Briarstone Rd.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic nephritis - E. mening</u>						<u>3 MOS</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive C.V. disease -</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>renal insufficiency -</u>						<u>5 YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					
22. I hereby certify that I attended the deceased from <u>APRIL 1, 1951</u> , to <u>Oct 27, 1955</u> , that I last saw the deceased alive on <u>Oct 27, 1955</u> , and that death occurred at <u>1:30 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thomas E. Schuler</u>		ADDRESS <u>M. D. 3601 Chiswick Rd. - Baltimore - 11-1-55</u>		DATE SIGNED <u>11-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/1/55</u>		REGISTRAR'S SIGNATURE <u>U. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Ellsworth Arlacost</u>		ADDRESS <u>4600 Liberty Hgts. Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

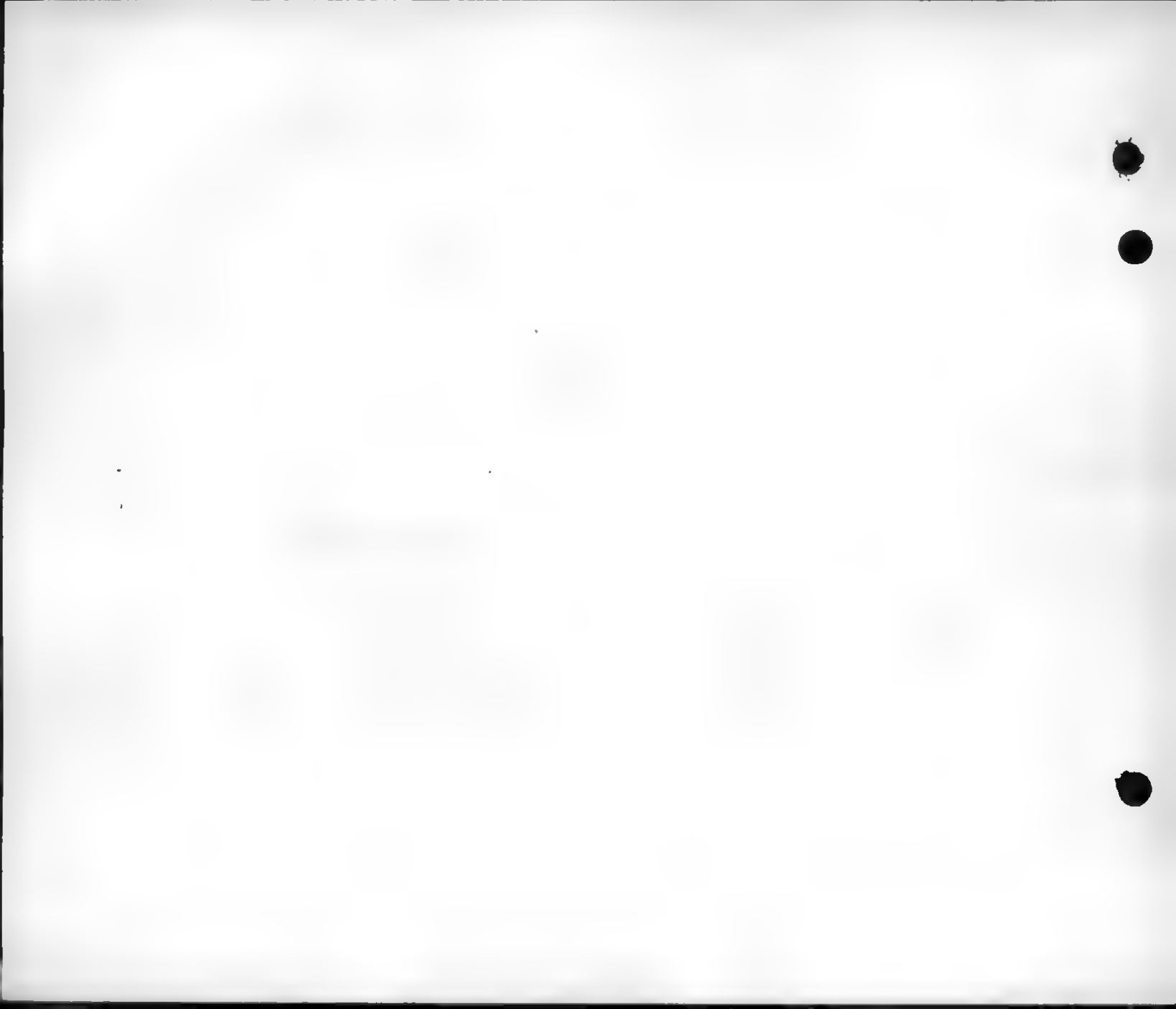
CERTIFICATE OF DEATH

Reg. Dist. No.

9552

09553

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) Ivy Hall TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS Ivy Hall, 19 Harrison Street Baltimore 20, Maryland				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Page CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luray STREET ADDRESS R.F.D. 4			
3. NAME OF DECEASED: (Type or Print) Lorah		(First) (Middle) (Last) Sours		4. DATE OF DEATH: 10 12 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: Oct. 8, 1886	9. AGE last birthday: 69 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Virginia			
13. FATHER'S NAME: William Judd			14. MOTHER'S MAIDEN NAME: Mary A. Judd				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Clifford Ellis - Raspeburg, Md.			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 153X Immediate cause (a) Secondary (metastatic) carcinoma of liver DUE TO Antecedent cause(s) (b) Carcinoma of colon DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) (260 X)					four weeks ? four weeks ?		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus					six years		
19a. DATE OF OPERATION: None		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) None		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 2, 1955 , to October 12, 1955 , that I last saw the deceased alive on Oct. 11, 1955 , and that death occurred at 5:50 p.m. , from the causes and on the date stated above.							
SIGNATURE Harvey L. Fuller		(DEGREE OR TITLE) M.D.		ADDRESS Ridge Road Baltimore 6, Md.			
DATE SIGNED October 12, 1955							
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF Oct. 15, 1955		NAME OF CEMETERY OR CREMATORY Family Cemetery			
LOCATION (City, town, or county) Luray		(State) Virginia					
24. FUNERAL DIRECTOR		ADDRESS Bradley Funeral Home Luray Va.					



MARYLAND STATE DEPARTMENT OF HEALTH

9395

2411 N. Charles Street, Baltimore

09554

CERTIFICATE OF DEATH

Reg. Dist. No. 42

Item 9, Film 187 10-19-55 et

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rebutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rebutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5100 Rebutus Ave.</u>		STREET ADDRESS (If rural give location) <u>5100 Rebutus Ave.</u>	
3. NAME OF DECEASED (Type or Print) First Middle Last <u>GEORGE E. SPALT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 11 - 55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 18, 1919</u>
9. AGE last birthday <u>66</u> yrs.	10a. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) <u>Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	13. FATHER'S NAME <u>John Spalt</u>	14. MOTHER'S MAIDEN NAME <u>Laura Bond</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY No. <u>26-12-3795-A</u>		17. INFORMANT <u>Bessie S. Spalt - 5100 Rebutus Ave.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>42.1</u>	(a) <u>MYOCARDIAL INFARCTION</u>	<u>5 hrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>GENERALIZED ARTERIOSCLEROSIS</u>	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Oct, 1955, to 11 Oct, 1955, that I last saw the deceased alive on 11 Oct, 1955, and that death occurred at 6 20 A m., from the causes and on the date stated above.

SIGNATURE George E. Grabeau (Degree or title) MO ADDRESS Elbridge 27, md DATE SIGNED 12 Oct 55

23. BURIAL/CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct. 14: 55</u>	<u>Landon Park Cem.</u>	<u>Baltimore - Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>10/13/55</u>	<u>A. W. Allen</u>	<u>W. H. Kippert</u>	<u>1300 Gaither Place</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09555

9553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch cliff near Towson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria General Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch cliff near Towson</u> STREET ADDRESS (If rural, give location) <u>Spennarm Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Rodriguez Speizer</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 2, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RL-1610U5</u>	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adam Speizer</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Hopfer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Dr. Mary Clara Villa Maria Md.</u>	
17. INFORMANT AND ADDRESS <u>Notch cliff</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)---

Coronary Occlusion. Sudden

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)---

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 1, 1950, to Oct. 14, 1955, that I last saw the deceased

alive on Oct. 13, 1955, and that death occurred at 12.55 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>10-17-55</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD.</u>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>October 15 1955</u>	<u>R.W.</u>	<u>Charles S. Zeller</u>	<u>901 S. CONKLE ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9554

09556

Reg. Dist. 44

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Balto #5</u>	
HOSPITAL OR INSTITUTION <u>In Mill assembly room</u>		STREET ADDRESS (If rural, give location)		ADDRESS <u>1428 E. Madison St.</u> ✓	
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) <u>Thomas</u> (Middle) (Last) <u>Spriggs</u>			(Month) <u>Oct</u> (Day) <u>7</u> (Year) <u>1955</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Ch.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Oct 6, 1910</u>		
9. AGE last birthday: <u>45</u>			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Janitor</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Belknap Steel</u>		
11. BIRTHPLACE (State or foreign country): <u>Annapolis Md</u>			12. CITIZEN OF WHAT COUNTRY: <u>U. S. A</u>		
13. FATHER'S NAME: <u>Matthew Diggs</u>			14. MOTHER'S MAIDEN NAME: <u>Katie Spriggs</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.: <u>Theresa Spriggs same</u>		
17. INFORMANT & ADDRESS:					

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p>420.1 Immediate cause (a)..... <u>Coronary occlusion</u></p> <p>DUE TO</p> <p>Antecedent cause(s) (b).....</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>				Interval Between Onset and Death: <u>Immediate</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF DEATH: <u>Oct 7 1955 6 A.M.</u>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>N. M. Barmine M.D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>10-10-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Brooklyn Mt.</u>	
DATE REC'D BY LOCAL REG. <u>10-10-55</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>Chas. O. Wilson 2004</u>	
				ADDRESS: <u>Ocean St.</u>	



9555

09550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

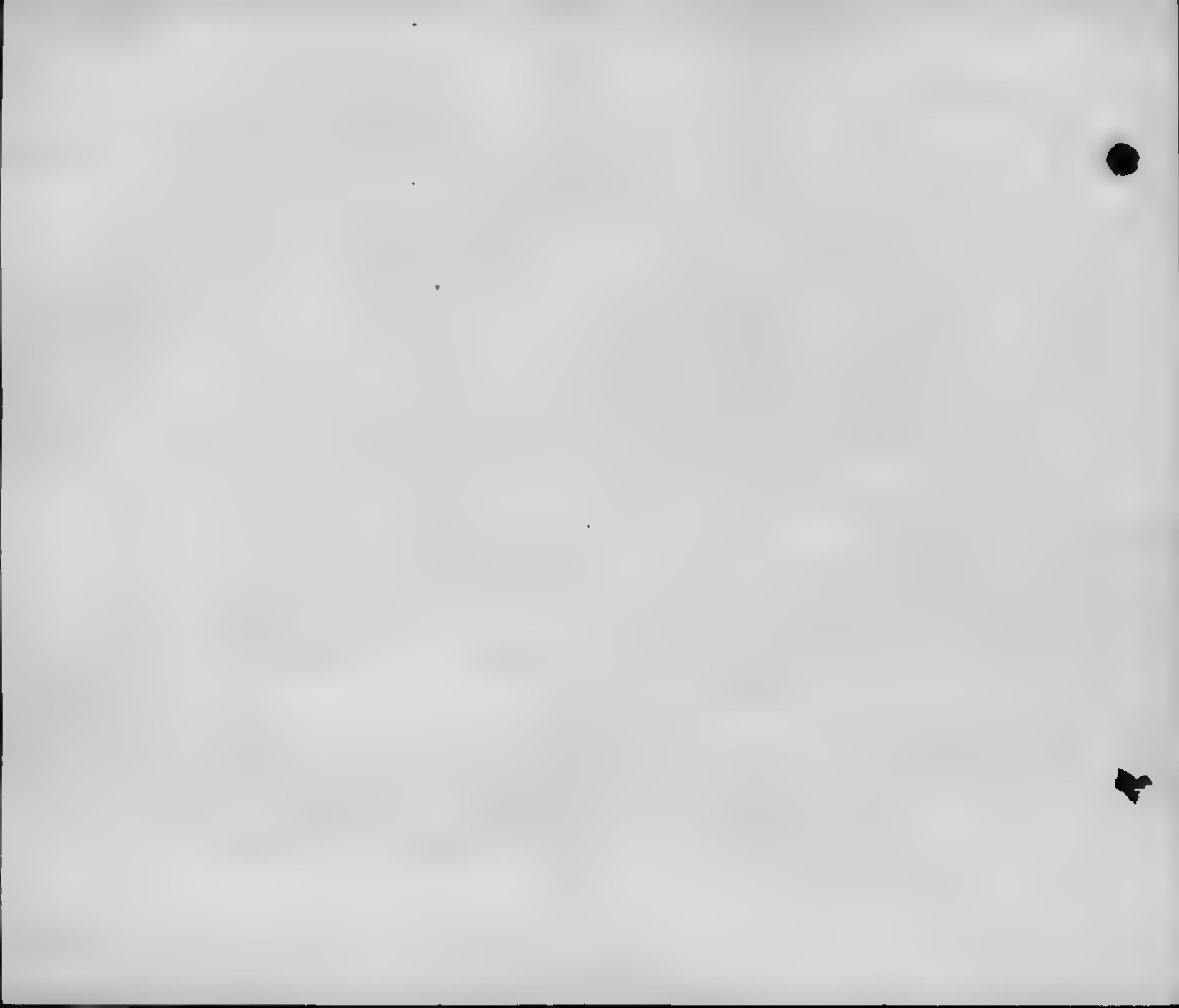
No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <i>Balto.</i>	LENGTH OF STAY (In this place) <i>5 yrs.</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Balto.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>6309 Windsor Mill Rd.</i>		STREET ADDRESS (If rural, give location) <i>6309 Windsor Mill Rd.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Roy</i>	(Middle) <i>MACK</i>	(Last) <i>SPROUSE</i>	(Month) <i>Oct</i> (Day) <i>24</i> (Year) <i>1965</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married Dec 19, 1894</i>	8. DATE OF BIRTH: <i>60</i> yrs.
9. AGE last birthday: <i>60</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Construction</i>	
11. BIRTHPLACE (State or foreign country): <i>Charlottesville, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME: <i>Robert S. Sprouse</i>		14. MOTHER'S MAIDEN NAME: <i>Georgia Marsh</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes.</i> (If Yes, give war or dates of service) <i>World War I</i>		16. SOCIAL SECURITY No.:	
17. INFORMANT'S ADDRESS: <i>Mrs Martha E. Marsh (Same address)</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)..... <i>Shot thru head & pistol</i>			<i>1 hr</i>
Antecedent cause(s) (b)..... <i>Depressed over Court. Summons</i>			<i>4 days</i>
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>			
19a. DATE OF OPERATION: <i>None</i>		19b. MAJOR FINDING OF OPERATION: <i>None</i>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <i>Home</i>	21c. (City or town) <i>6309 Windsor Mill Rd. Balto.</i>	(State) <i>Md.</i>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>Oct 24 33 9 A.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Shot himself.</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>D. D. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>10-24-65</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>Oct 26, 1965</i>	NAME OF CEMETERY OR CREMATORY: <i>Baltimore National Cem</i>	LOCATION (City, town or county) (State): <i>Balto Maryland</i>
DATE REC'D BY LOCAL REG: <i>10/24/65</i>	REGISTRAR'S SIGNATURE: <i>G. W. Aldrich</i>	24. FUNERAL DIRECTOR: <i>Greenwald & Son</i> ADDRESS: <i>4600 Liberty Heights Avenue</i>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9556

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Parkton</u>	<u>81 yrs.</u>	TOWN <u>Parkton</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Main St.</u>		<u>Main St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
<u>Pleasant A. Stiffler</u>		<u>October 17, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>August 15, 1874</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday
<u>Mail carrier</u>		<u>U.S. Mail</u>	<u>81</u> yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Parkton, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Stiffler</u>		<u>Sarah Baublitz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>No</u>		<u>Mrs. Ella Stiffler, Parkton, Md.</u>	

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Carcinoma of the Colon</u>		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		

22. I hereby certify that I attended the deceased from, 1954, to Oct. 17, 1955, that I last saw the deceased alive on Oct. 17, 1955, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<u>A. M. France</u>	<u>Parkton, Md.</u>	<u>10/19/55</u>
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>Oct. 20, 1955</u>	<u>Pine Grove Cemetery, Parkton, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>10/30/55</u>	<u>Charles J. Eubank</u>	<u>Jacob Hartenstein, New Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9557
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09558
Reg. Dist.

No. 36

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Cockeysville</i>	LENGTH OF STAY (in this place) <i>6 hours</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Freeland</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Baltimore County Police Station</i>		STREET ADDRESS (If rural, give location) <i>Ruhl Rd.</i>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <i>Walter</i> (Middle) <i>Henry</i> (Last) <i>Stiffler</i>		(Month) <i>Oct.</i> (Day) <i>4</i> (Year) <i>1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>November 8, 1897</i>
9. AGE last birthday: <i>57</i> yrs.		10. IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Mln. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Mechanic</i>	10b. KIND OF BUSINESS OR INDUSTRY: <i>Quarry</i>	11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md.</i>	
13. FATHER'S NAME: <i>Arthur Stiffler</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>	
14. MOTHER'S MAIDEN NAME: <i>Susan Ruhl</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY No.: <i>204-05-2909</i>		17. INFORMANT & ADDRESS: <i>Mrs. Stiffler - Glen Rock, Pa.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <i>Asphyxiation, strangulation by hanging</i>		<i>Sudden</i>
Antecedent cause(s) (b) <i>giving rise to the above cause</i>		
stating underlying cause last (c) <i>Chronic alcoholism</i>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Rollin C. Hudson</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>10/4/55</i>
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>October 8, 1955</i>	NAME OF CEMETERY OR CREMATORY: <i>Stiltz Cemetery</i>
DATE REC'D BY LOCAL REG: <i>10/8/55</i>	REGISTERAR'S SIGNATURE: <i>Charles F. Fulton</i>	LOCATION (City, town, or county) (State): <i>Glen Rock, Pa. R.D.3.</i>
		24. FUNERAL DIRECTOR: <i>Jacob Kastenstern</i>
		ADDRESS: <i>New Freedom, Pa.</i>



9558

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X TOWN <u>Freeland</u>	<u>50 yrs.</u>	<u>Freeland</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Main St.</u>		<u>Main St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Howard</u>	(Middle) <u>E.</u>	(Last) <u>Sutton</u>	(Month) <u>October</u> (Day) <u>19</u> (Year) <u>1955</u>
(Type or Print)			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 11, 1879</u>
		9. AGE last birthday: <u>76</u> yrs.	10. AGE last birthday: IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>	11. BIRTHPLACE (State or foreign country): <u>Balto. Co., Md.</u>
12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Jefferson Sutton</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Elizabeth Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.:	
		17. INFORMANT'S ADDRESS: <u>Kenneth Sutton, Freeland, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE: <u>470.0</u>		(A) <u>Arteriosclerotic Heart Disease</u> <u>10 yrs.</u>	
ANTECEDENT CAUSE (S):		DUE TO (B) <u>Arteriosclerosis</u> <u>20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO (C) <u>none</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>None</u>		<u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>November 1955</u> , to <u>Oct. 1955</u> , that I last saw the deceased alive on <u>10-6</u> , 1955, and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE: <u>Lucia Schatanoff</u>		ADDRESS: <u>New Freedom, Pa.</u>	
DATE SIGNED: <u>10/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>Oct. 22, 1955</u>	
NAME OF CEMETERY OR CREMATORY: <u>Mt. Zion Cemetery</u>		LOCATION (City, town, or county) (State): <u>Freeland, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>10/20/55</u>		REGISTRAR'S SIGNATURE: <u>Charles J. Sutton</u>	
FUNERAL DIRECTOR: <u>Jacob Hartenstein</u>		ADDRESS: <u>New Freedom, Pa.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09560

9559

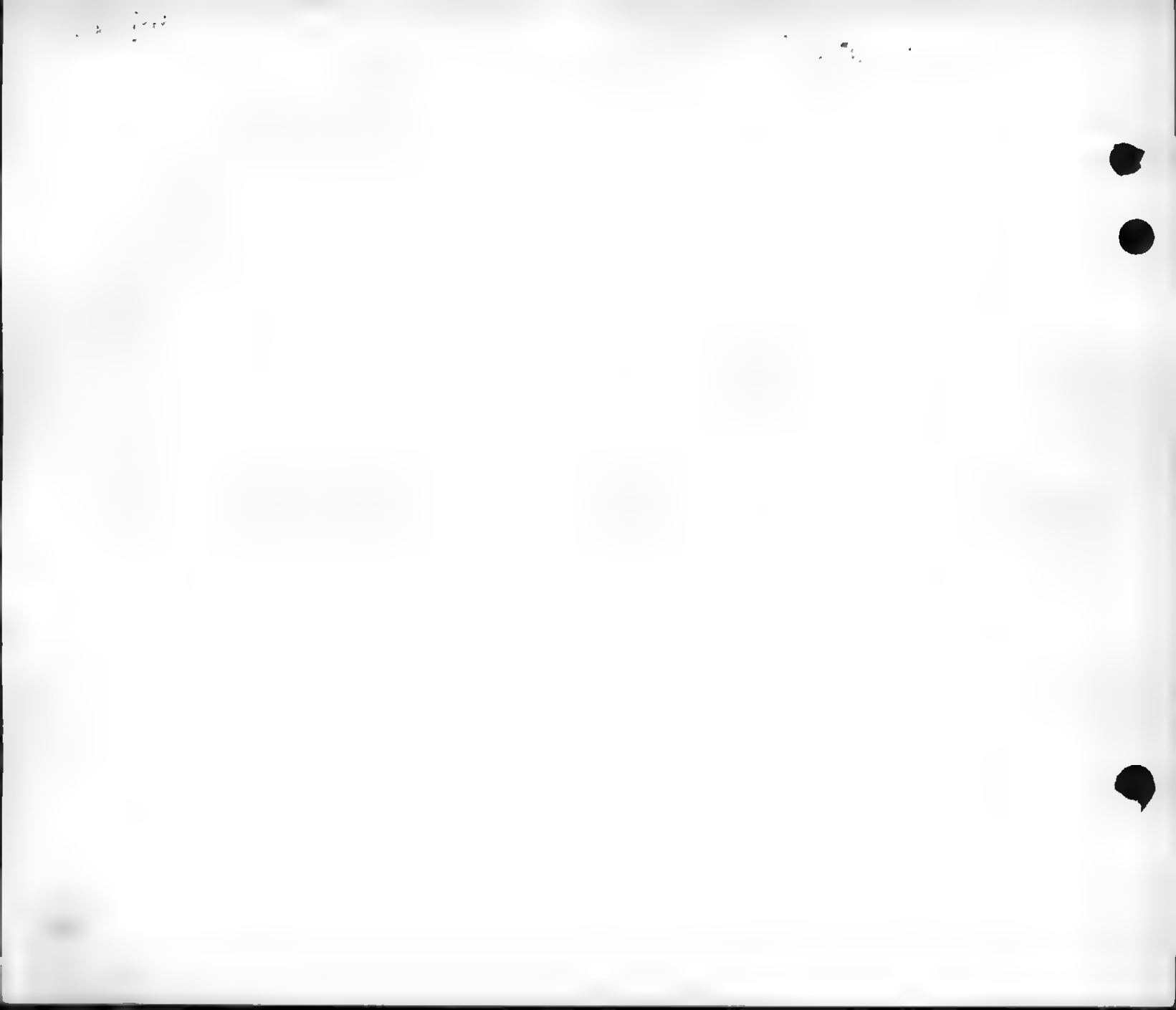
CERTIFICATE OF DEATH

Item 12 Film 6188 10-28-55 et

Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTIMORE</u> MARYLAND			STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town			CITY (If outside corporate limits, write RURAL and give nearest town) OR		
X TOWN <u>LYNCH POINT</u> 50 YRS			TOWN <u>LYNCH POINT</u> X		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
00 <u>3206 GRACE ROAD</u>			<u>3206 GRACE ROAD</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>MARY BOKA SZALAI</u>			<u>OCT 20 1955</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>FEB 13, 1879</u>		<u>76</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):
<u>AT HOME</u>					<u>HUNGARY</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>JOSEPH BOKA</u>			<u>DONT KNOW</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:
<u>NO</u>			<u>-</u>		<u>MRS. MARY YOWELL 3206 GRACE RD.</u>

18. MEDICAL CERTIFICATION						Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
<u>175X</u>						
Immediate cause (a) ... <u>Enterocryptic fistula</u>						<u>1 week</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ... <u>Ovarian Carcinoma</u>						<u>at least 1 year.</u>
(c)						
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY ?
						Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE HOMICIDE		INJURY				
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>October 20, 1955</u> , that I last saw the deceased alive on <u>October 18, 1955</u> , and that death occurred at <u>3:20 AM</u> , from the causes and on the date stated above.						
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED
<u>Harold Owens M.D.</u>				<u>914 D Street Balto. 19</u>		<u>10/20/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
<u>BURIAL</u>		<u>OCT 22, 1955</u>		<u>BECAIR MEMO.</u>		<u>BECAIR MD</u>
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS
<u>10/25/55</u>		<u>H.W. Nelson</u>		<u>ULLRICH FUNERAL HOME</u>		<u>DUNDALK</u>



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **09561**

9560

CERTIFICATE OF DEATH

Reg. Dist. No. **33**

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Glyndon</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glyndon</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Central Avenue</u>			STREET ADDRESS (If rural give location) <u>11 Central Avenue</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Alexander Talbert</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct 23 1955</u>		
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>February 5 1872</u> 83 yrs.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired farmer</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm manager</u>		
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>William Fletcher Talbert</u>			14. MOTHER'S MAIDEN NAME: <u>Martha M Warfield</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give way or dates of service) <u>No</u>			16. SOCIAL SECURITY No. <u>None</u>		
17. INFORMANT & ADDRESS: <u>Miss Florence Talbert Glyndon Md</u>					
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>443X</u>					
(A) <u>Cardiac Decompensation</u>					<u>3 wks.</u>
ANTECEDENT CAUSE (S):					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(B) <u>Hypertensive Cardio Vascular Disease</u>					<u>3 yrs.</u>
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>					
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>none</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <u>none</u>		21F. HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I attended the deceased from Jan. 13, 1950 to Oct. 23, 1955, that I last saw the deceased alive on Oct. 22, 1955 and that death occurred at 4:30 AM, from the causes and on the date stated above.					
SIGNATURE <u>A. D. Caplan</u>		ADDRESS <u>M. D. Reisterstown, Md.</u>		DATE SIGNED <u>10-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 25 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St Thomas Cemetery</u> LOCATION (City, town, or county) <u>Owings Mills</u> (State) <u>Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-24-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Wm Berryman & Sons</u> ADDRESS <u>Reisterstown Md</u>	

9386

CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>DUNDALK 22</u>		LENGTH OF STAY (in this place) <u>3 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7507 LAWRENCE Rd</u>				STREET ADDRESS (If rural give location) <u>7507 LAWRENCE Rd</u>			
3. NAME OF DECEASED: (First) <u>HARLEN</u> (Middle) <u>ARLINGTON</u> (Last) <u>TAULTON</u>				4. DATE OF DEATH: (Month) <u>10</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>SEPT. 10, 1915</u>	
				9. AGE last birthday: <u>50</u> yrs.		10. AGE last birthday: If UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>STAMPER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>SOAP MFR.</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>FRANK A. TAULTON</u>				14. MOTHER'S MAIDEN NAME: <u>FANNY WEBER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>100</u>				16. SOCIAL SECURITY No.: <u>288-01-121</u>			
				17. INFORMANT & ADDRESS: <u>W. TAULTON - SAME.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death <u>1 YR.</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>Immediate cause (a) <u>CORONARY THROMBOSIS</u></p> <p>Antecedent causes (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u></p> <p>giving rise to the above cause stating the underlying cause last. (c)</p>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION		

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE	
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
OF INJURY	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1955, to Oct 21, 1955, that I last saw the deceased alive on Oct 18, 1955, and that death occurred at 8:35 AM from the causes and on the date stated above.

SIGNATURE J. Kefauver M.D. (Degree or title) ADDRESS 6714 Highland Ave DATE SIGNED 10/22/55

23. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>		DATE THEREOF <u>10-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>ARK</u>		LOCATION (City, town, or county) (State) <u>BALTO. CO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 23-1955</u>		REGISTRAR'S SIGNATURE <u>William M Kelly</u>		24. FUNERAL DIRECTOR		ADDRESS <u>1111 N. ...</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9551

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fert Howard</u>		<u>1d</u> days		TOWN <u>Baltimore</u>		<u>3 Vol 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1618 W. Fayette Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LESTER TERRY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 24 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11/28/22</u>	9. AGE last birthday <u>32</u> yrs.	IF UNDER 1 YEAR (Months) (Days)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Vance County North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Terry</u>				14. MOTHER'S MAIDEN NAME <u>Flora Eaton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW II</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT & ADDRESS <u>VA Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>LAENNEC'S CIRRHOSIS</u>						UNKNOWN	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>MALNUTRITION, SEVERE</u>						UNKNOWN	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 13, 1955</u> to <u>October 24, 1955</u> , that he was deceased at <u>1:30 P.M.</u> and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>F. S. Dickey MD</u>				ADDRESS (Street, city, town, state) <u>Francis G. Dickey, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>10-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>10/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Antioch Cemetery</u>		LOCATION (City, town, or county) (State) <u>Vance County, N. Carolina</u>	
24. REC'D BY REGISTRAR <u>Oct 26-55 Dawson E. Traylor</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law Mortuary</u>		ADDRESS <u>802-04 Madison Ave., Baltimore 1, Md.</u>	

Shipped to: Garnes & Williams, Henderson, N., Carolina Ave., Baltimore 1, Md.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9562

CERTIFICATE OF DEATH

09564

Reg. Dist. No. 39

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Monkton</u> TOWN <u>Monkton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Corbett Rd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix</u> TOWN <u>Phoenix</u> STREET ADDRESS (If rural give location) <u>Carroll Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Louis</u> (First) <u>Gartfield</u> (Middle) <u>Thomas</u> (Last)		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>22</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11 Sept. 1894</u>
9. AGE last birthday <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Rayville, Balto Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Fenrietta Bosley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-34-1454</u>	
17. INFORMANT & ADDRESS <u>Ethel Lillian Thomas, Phoenix, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>over 7 years</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Jan 17 Oct 1955</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 17 Oct 1955</u> , to <u>12:45 P</u> , that I last saw the deceased alive on <u>17 Oct 1955</u> , and that death occurred at <u>12:45 P</u> , from the causes and on the date stated above.			
SIGNATURE <u>Walter T. Lees</u>		DATE SIGNED <u>22 Oct 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-25-55</u>	
24. REC'D BY REGISTRAR <u>M. Elizabeth Gorsuch</u>		REGISTRAR'S SIGNATURE <u>St. Lukes Methodist Herford, Balto Co. Md.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks, Sparks, Md.</u>		ADDRESS (Street, city, town, state)	



9396

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Howard</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Halethorpe</u>	<u>3 months</u>	OR TOWN <u>Annapolis Junction</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>1906 North Eastern</u>		<u>R.F.D. 13X-2</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>SAMUEL</u>	(Middle) <u>S</u>	(Last) <u>JIMMONS</u>	(Month) <u>Oct</u> (Day) <u>11</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
		<u>Married</u>	<u>Oct 31, 1870</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>84 yrs.</u>		<u>Wash. D.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
<u>messenger in Government</u>		<u>Born at Sea U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Unknown</u>		<u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>Mrs. Grace B. Keegin</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>4 mos.</u>	
IMMEDIATE CAUSE (A) <u>Cardiovascular disease</u>			
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerosis, Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Edema</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While at work Not while at work	
22. I hereby certify that I attended the deceased from <u>June 1955</u> to <u>October 11, 1955</u> that I last saw the deceased alive on <u>Oct 10, 1955</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>Oct 14, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial Oct 14, 1955 - St. Lawrence</u>		<u>Jesus Md</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>Oct 14, 1955</u>		<u>Ridgely, Md. 401 Wash Ave</u>	

MARGIN RESERVED FOR BINDING

177

THE
LIBRARY OF THE
MUSEUM OF NATURAL HISTORY
AND
HUMAN ANTHROPOLOGY
OF THE
SMITHSONIAN INSTITUTION
WASHINGTON, D. C.

177

THE
LIBRARY OF THE
MUSEUM OF NATURAL HISTORY
AND
HUMAN ANTHROPOLOGY
OF THE
SMITHSONIAN INSTITUTION
WASHINGTON, D. C.

177

MARYLAND

9563

CERTIFICATE OF DEATH

09566
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1103 HARWALL RD.</u>		STREET ADDRESS (If rural, give location) <u>1103 HARWALL RD.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>J.</u> (Middle) <u>LESTER</u> (Last) <u>TOPPER</u>	4. DATE OF DEATH (Month) <u>OCT.</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-23-1894</u>
9. AGE last birthday <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STORE MANAGER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JACOB TOPPER</u>		14. MOTHER'S MAIDEN NAME <u>ADALADE WACERMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>1-1-1</u>	
17. INFORMANT AND ADDRESS <u>Mr. J. L. Topper - 1103 Harwall Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
151X Immediate cause (a) <u>Inoperable Carcinoma of Stomach.</u>			
Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Infection</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1, 1955</u> , to <u>10/17/55</u> , that I last saw the deceased alive on <u>10/14/55</u> , and that death occurred at <u>8:35 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>F. Fred Loker, M.D.</u>		DATE SIGNED <u>10/19/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE <u>10-20-55</u>		LOCATION (City, town, or county) <u>catonsville</u>	
DATE REC'D BY LOCAL REG. <u>10/19/55</u>		REGISTRAR'S SIGNATURE <u>J. E. Barry</u>	
		24. FUNERAL DIRECTOR <u>W. H. ...</u>	

JOHN V. S.

1911

9554

CERTIFICATE OF DEATH

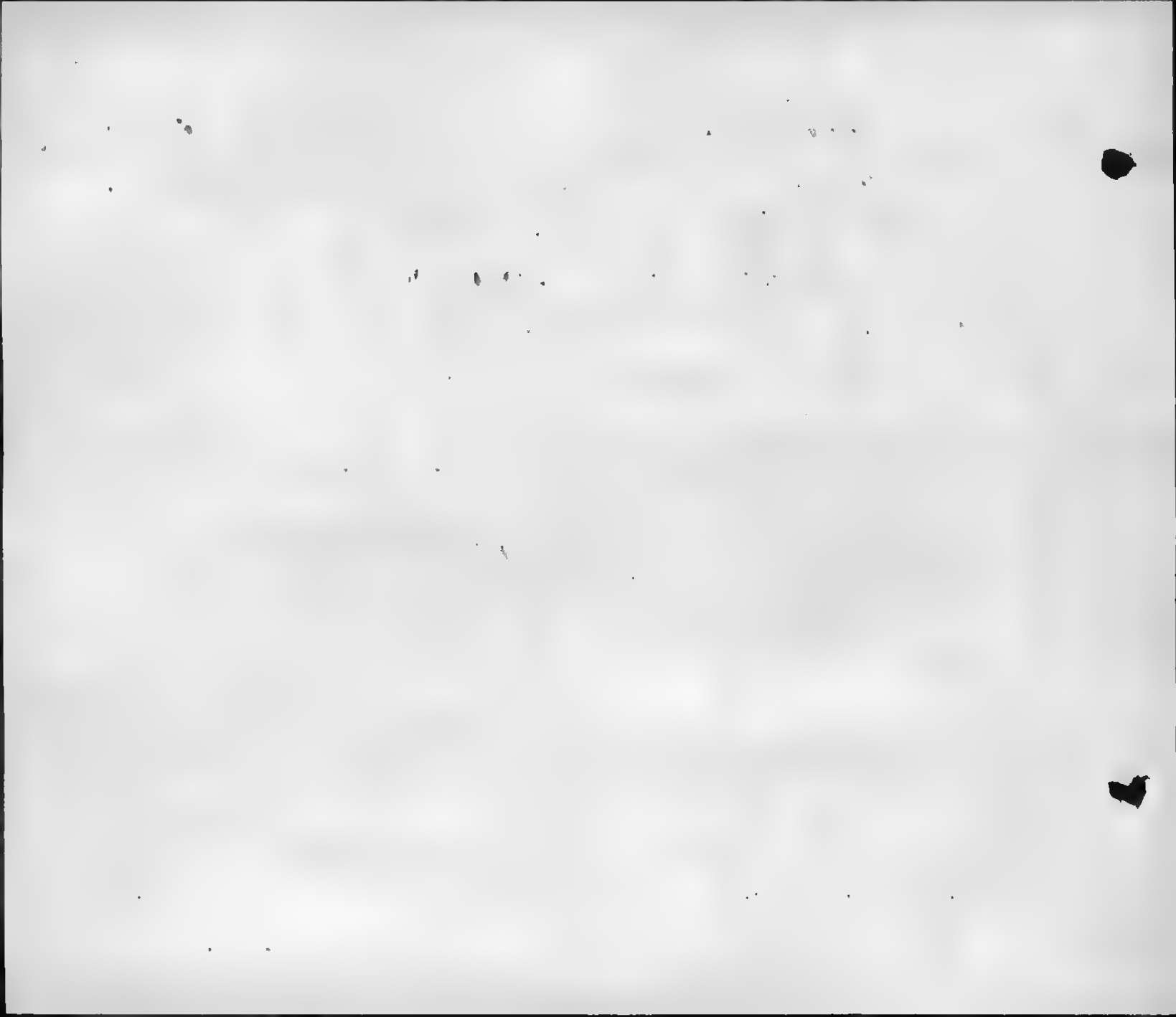
Reg. Dist. No.

36

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>14 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Severna Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>		STREET ADDRESS (if rural give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
<u>FRANK A VINTON</u>		OF DEATH: <u>10 4 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 20, 1870</u>
9. AGE last birthday: <u>85 yrs.</u>		10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Printer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Publisher</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Thomas Vinton</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (if Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-1794</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Emma E. Vinton - Severna Park, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>			
ANTECEDENT CAUSE (B) <u>Dehydration & Malnutrition</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Renal Failure.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/20/55</u> to <u>10/4/55</u> , that I last saw the deceased alive on <u>10/4</u> , 19 <u>55</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>SPRING GROVE HOSPITAL</u>		DATE SIGNED <u>10/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cen.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-6-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Md. Balto 17</u>	

MARGIN RESERVED FOR INDEXING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Ruston LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 1100 Boyce Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Pennsylvania COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Steeleton
 STREET ADDRESS 132 Lincoln Street

3. NAME OF DECEASED:

(First) CAROLINE (Middle) C. (Last) WAGENBACH
 (Type or Print)

4. DATE OF DEATH: Oct. 27 19 55
 (Month) (Day) (Year)

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Single

8. DATE OF BIRTH:

June 24, 1886

9. AGE last birthday:

79 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Steeleton, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Earnest S. Wagenbach

14. MOTHER'S MAIDEN NAME:

Bernietta P.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Sister Martha 1100 Boyce Ave.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause

(a)

Hyperbensive - Cardio-vascular

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

disease

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1939, to 10-27, 1955, that I last saw the deceased

alive on 10-26, 1955, and that death occurred at 7:05 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Nov. 1, 1955

NAME OF CEMETERY OR CREMATORY

Steeleton Pa.

LOCATION (City, town, or county, State)

Steeleton Pa.

DATE REC'D BY LOCAL REGISTRAR

10-27-55

REGISTRAR'S SIGNATURE

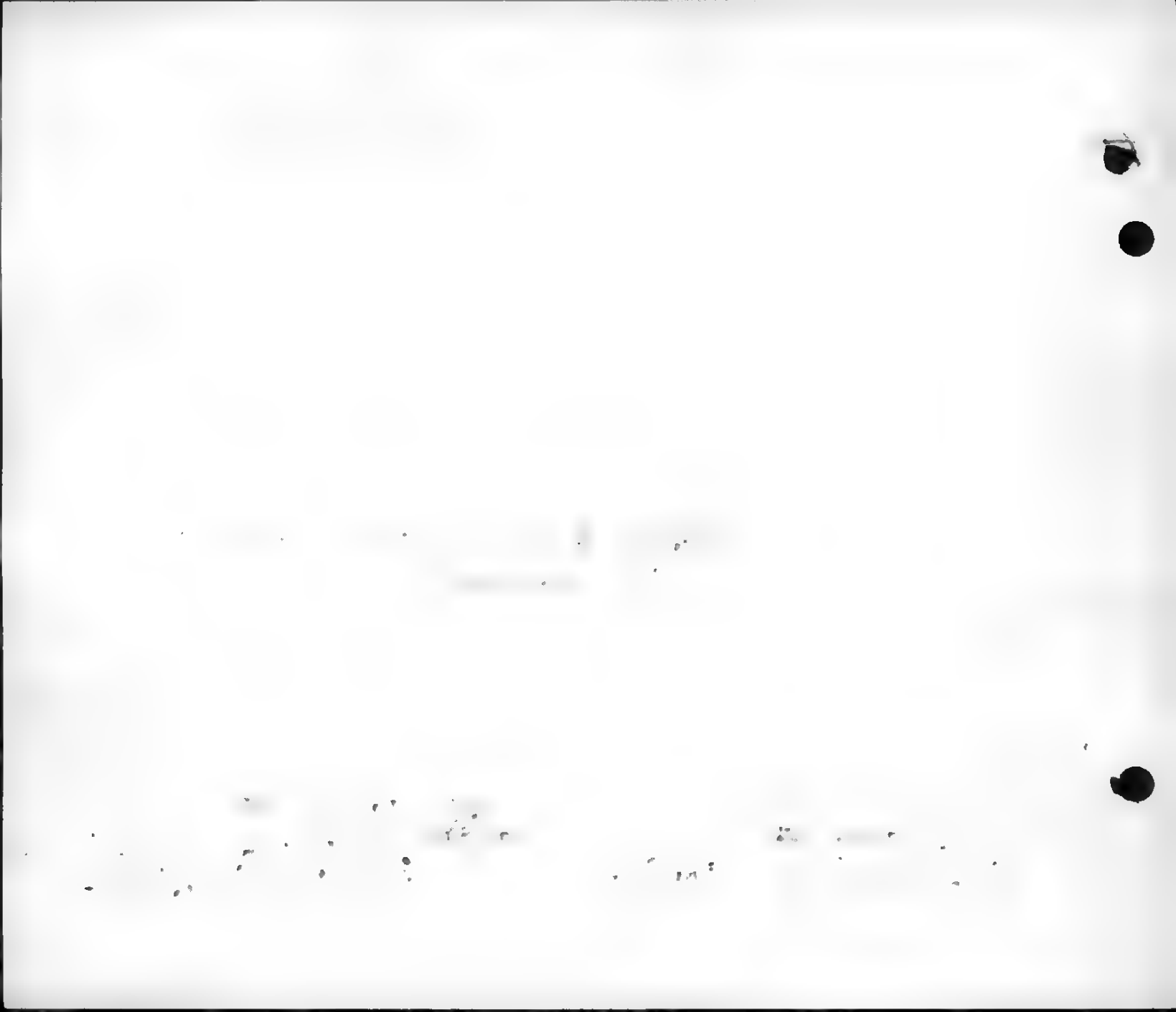
24. FUNERAL DIRECTOR.

ADDRESS

J. B. Wippet 1300 Guttman Place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9556

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural-Glen Rock</u>	LENGTH OF STAY (in this place) <u>72 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural-Glen Rock.</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Stiltz.</u>		STREET ADDRESS (If rural give location) <u>Stiltz.</u>	

3. NAME OF DECEASED: (Type or Print) <u>Charles H. Walker.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>October 22, 1955.</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 17, 1882</u>
9. AGE last birthday <u>72</u> yrs.		10. MONTHS <u>72</u>	11. DAYS <u>72</u>

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm.</u>	11. BIRTHPLACE (State or foreign country): <u>Glen Rock, Pa. R.D.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
--	---	---	--

13. FATHER'S NAME: <u>Daniel Walker.</u>	14. MOTHER'S MAIDEN NAME: <u>Susan Nace.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <u>No</u>	16. SOCIAL SECURITY NO. <u> </u>
17. INFORMANT & ADDRESS: <u>Mrs. Cora Walker, Glen Rock, Pa.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Acute Myocarditis</u>		<u>8 mos.</u>
ANTECEDENT CAUSE (B) <u>Coronary Thrombosis</u>		<u>immediate death</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

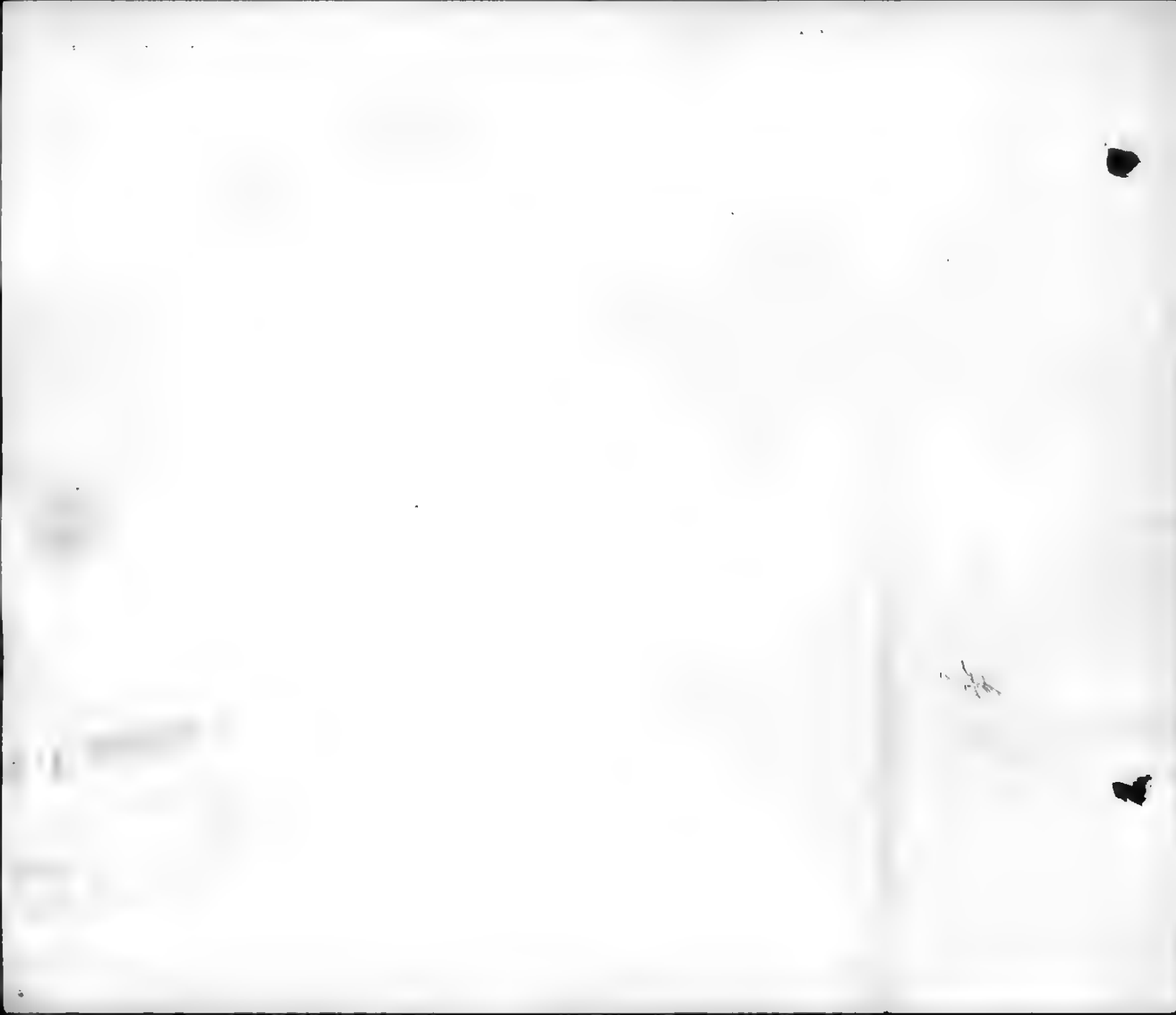
22. I hereby certify that I attended the deceased from Mar, 1955, to Oct 22, 1955, that I last saw the deceased alive on Oct. 18, 1955, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE O. W. Summit M D ADDRESS Codomo, Pa. DATE SIGNED Oct. 22, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>	DATE THEREOF: <u>Oct. 25, 1955</u>	NAME OF CEMETERY OR CREMATORY: <u>Stiltz Cemetery</u>	LOCATION (City, town, or county) (State): <u>Glen Rock, Pa. R.D. 3.</u>
DATE REC'D BY LOCAL REGISTRAR: <u>10/25/55</u>	REGISTRAR'S SIGNATURE: <u>Charles J. Friedman</u>	24. FUNERAL DIRECTOR: <u>Jacob Hartenstein</u>	ADDRESS: <u>New Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9557

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

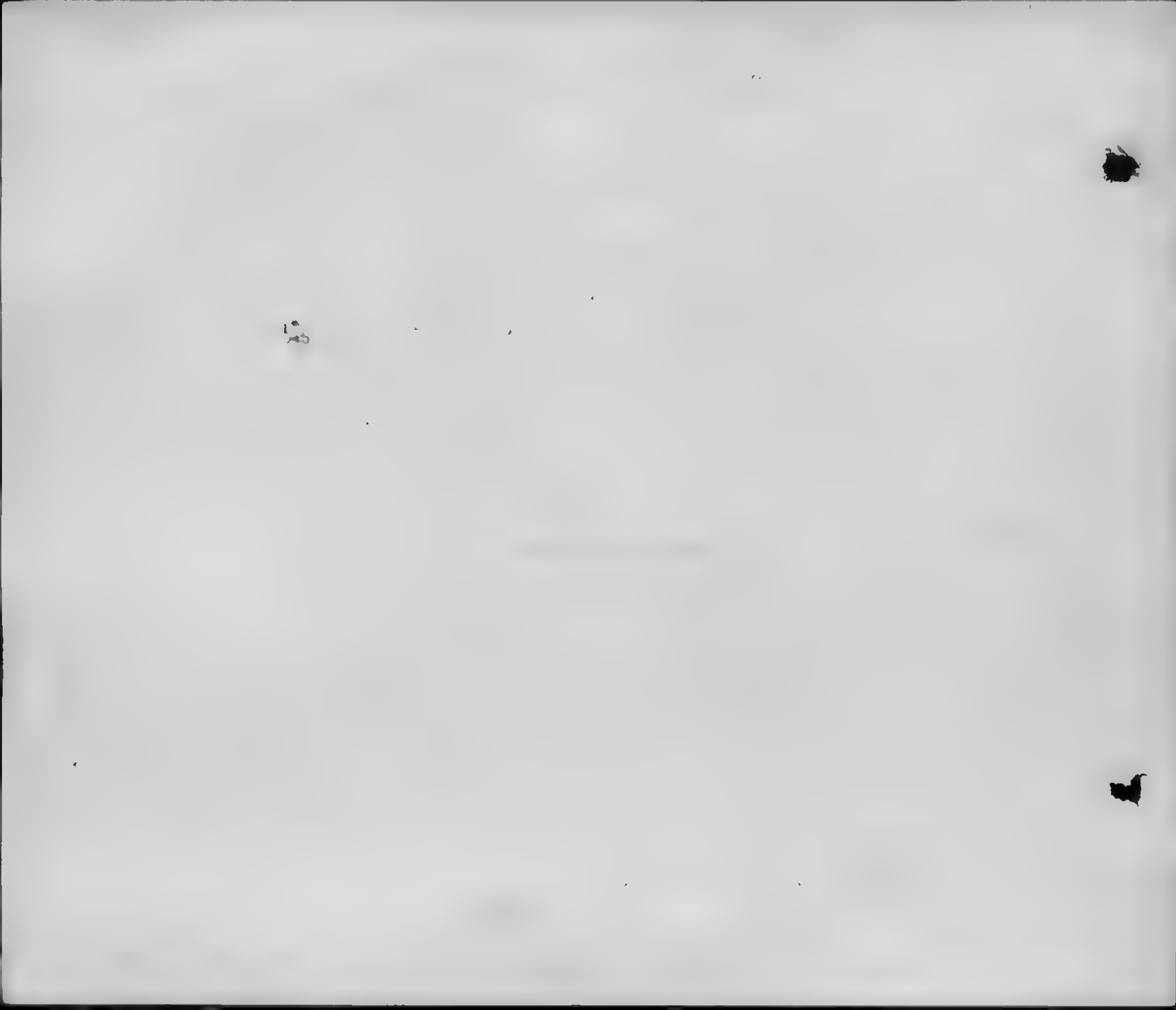
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. ...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>...</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Linthicum</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>		STREET ADDRESS (If rural, give location) <u>206 E Maple Rd.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Harvey</u> (Middle) <u>Cheill</u> (Last) <u>Webster Jr.</u>		(Month) <u>10</u> (Day) <u>-23</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify): <u>...</u>	8. DATE OF BIRTH: <u>2-14-1883</u>
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Ins. Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Life Insurance</u>	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>David P. Webster</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Washington Shores</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Sophia Webster - Same as # 2</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) ... <u>Terminal pneumonia</u>			<u>5 days</u>
DUE TO			
Antecedent cause(s) (b) ... <u>Decumitus gangrene</u>			<u>2 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			<u>less than</u>
stating underlying cause last (c) <u>Fracture left hip</u>			<u>3 months</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive cardiovascular disease</u>			<u>years</u>
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>Hospward</u>	
21c. (City or town) (County) (State) <u>Catonsville Baltimore Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 29, 1955 5-30 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Another patient pushed him causing him to fall to floor</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
SIGNATURE <u>George S. M. Kieffer, M.D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10.26.55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		LOCATION (City, town, or county) (State) <u>Ellicott City.</u>	
DATE REC'D BY LOCAL REG. <u>10/26/55</u>		REGISTRAR'S SIGNATURE <u>Wm. J. ...</u>	
24. FUNERAL DIRECTOR <u>Wm. J. ...</u>		ADDRESS <u>...</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

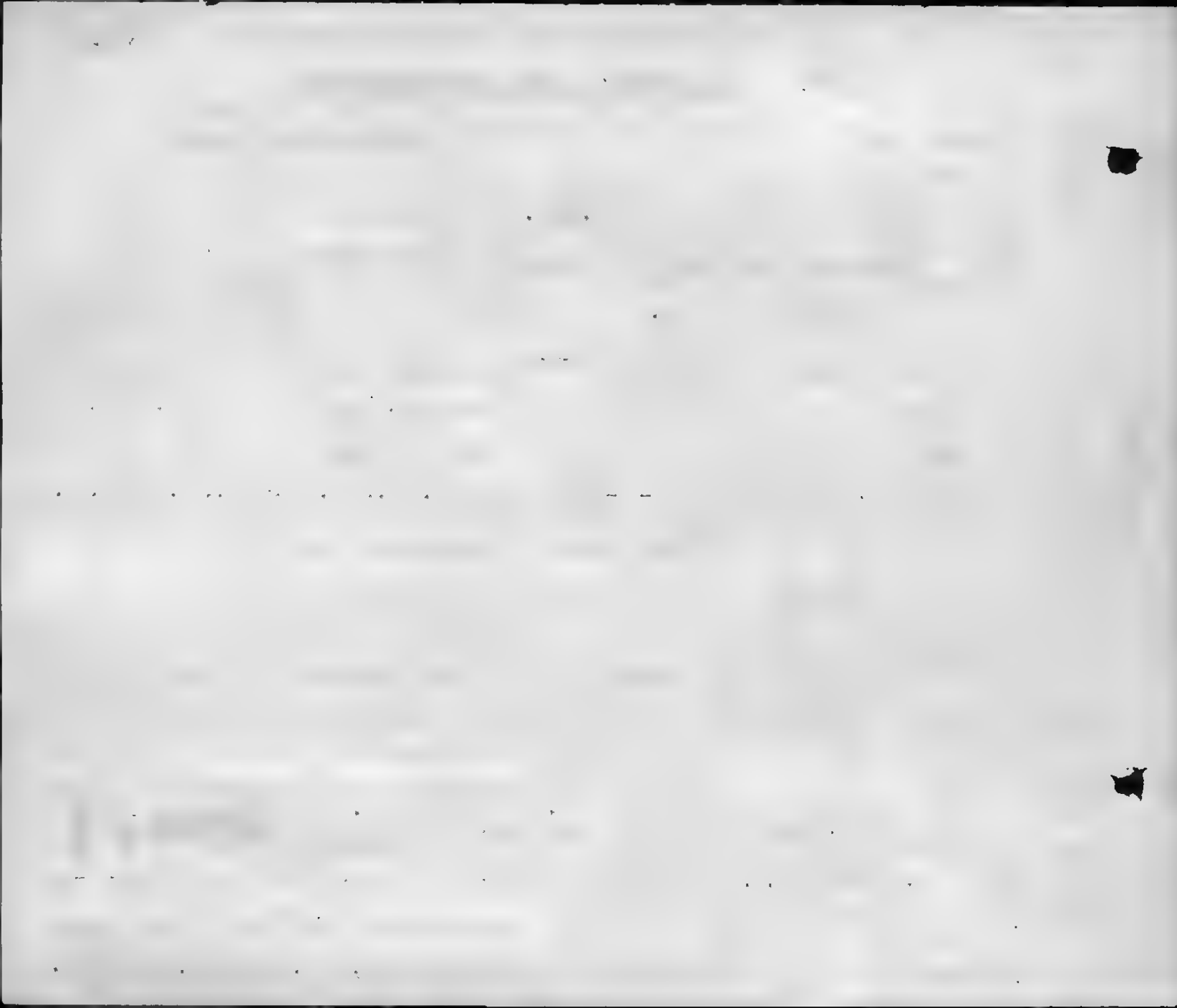
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9568

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>4 Hrs. 40 M.</u>		TOWN <u>Baltimore</u>		<u>3rd 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1800 Barclay Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>CHARLES F. WELSH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 28 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>7-2-94</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Welsh</u>				14. MOTHER'S MAIDEN NAME <u>Mary McCauley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-18-7976</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>541.0 IMMEDIATE CAUSE (A) DUODENAL ULCER WITH HEMORRHAGE</u>						<u>24 HOURS</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>10:10 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 28 5:30 PM</u> to <u>Oct. 28 10:10 PM</u> , 19 <u>55</u> , and that death occurred at <u>10:10 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur G. Edwards</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>10-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Rawson L. Barber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Forace, Inc.</u>		ADDRESS <u>712-11 E. North Ave. Baltimore, Maryland</u>	



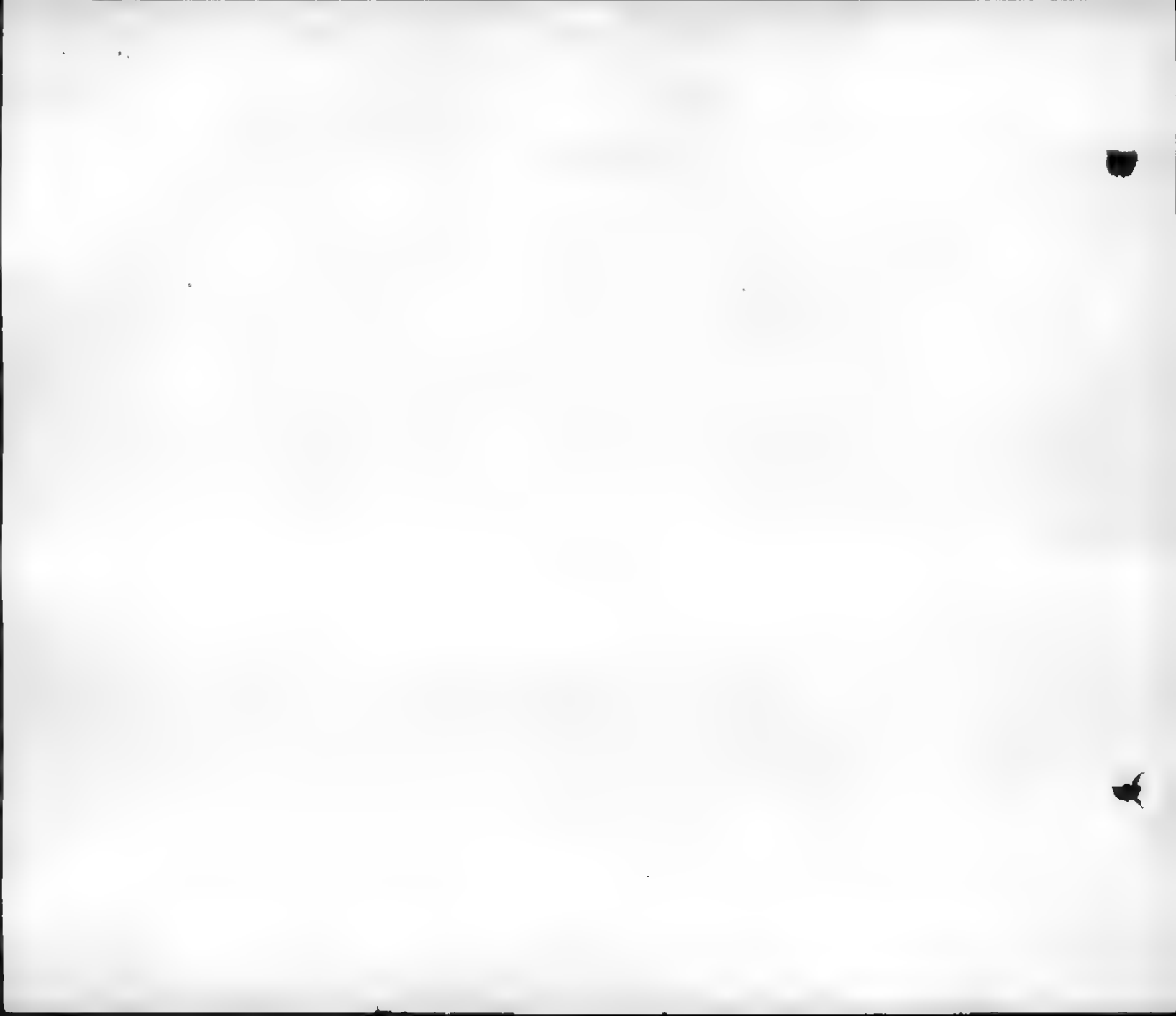
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09573

9569 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>912 Dulaney Court Apt's</u>				STREET ADDRESS (If rural give location) <u>912 Dulaney Court Apt's</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Mary G. Welsh</u> (Middle) (Last)				(Month) (Day) (Year) <u>Oct. 22, 1955</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH: <u>Oct. 27, 1885</u>	
9. AGE last birthday <u>69 yrs.</u>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Belfast Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>William Hamilton</u>			
14. MOTHER'S MAIDEN NAME: <u>Catherine Gunn</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS: <u>Mrs. Rob't F. Strangmann 7101 Bristol Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						IMMEDIATE CAUSE (A) <u>Coronary artery occlusion</u>	
ANTECEDENT CAUSE (B) DUE TO						DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						DUE TO	
(C)						DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT 18, 1955</u> , to <u>OCT 22, 1955</u> , that I last saw the deceased alive on <u>SEPT 21, 1955</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Thaddens C. Swinski</u>		ADDRESS <u>17 W. PENNIA. AVE</u>		DATE SIGNED <u>OCT 24, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 23 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/24/55</u>		REGISTRAR'S SIGNATURE <u>U. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>William J. Zuker + Sons</u>			
ADDRESS		ADDRESS <u>17 W. PENNIA. AVE</u>					



9570

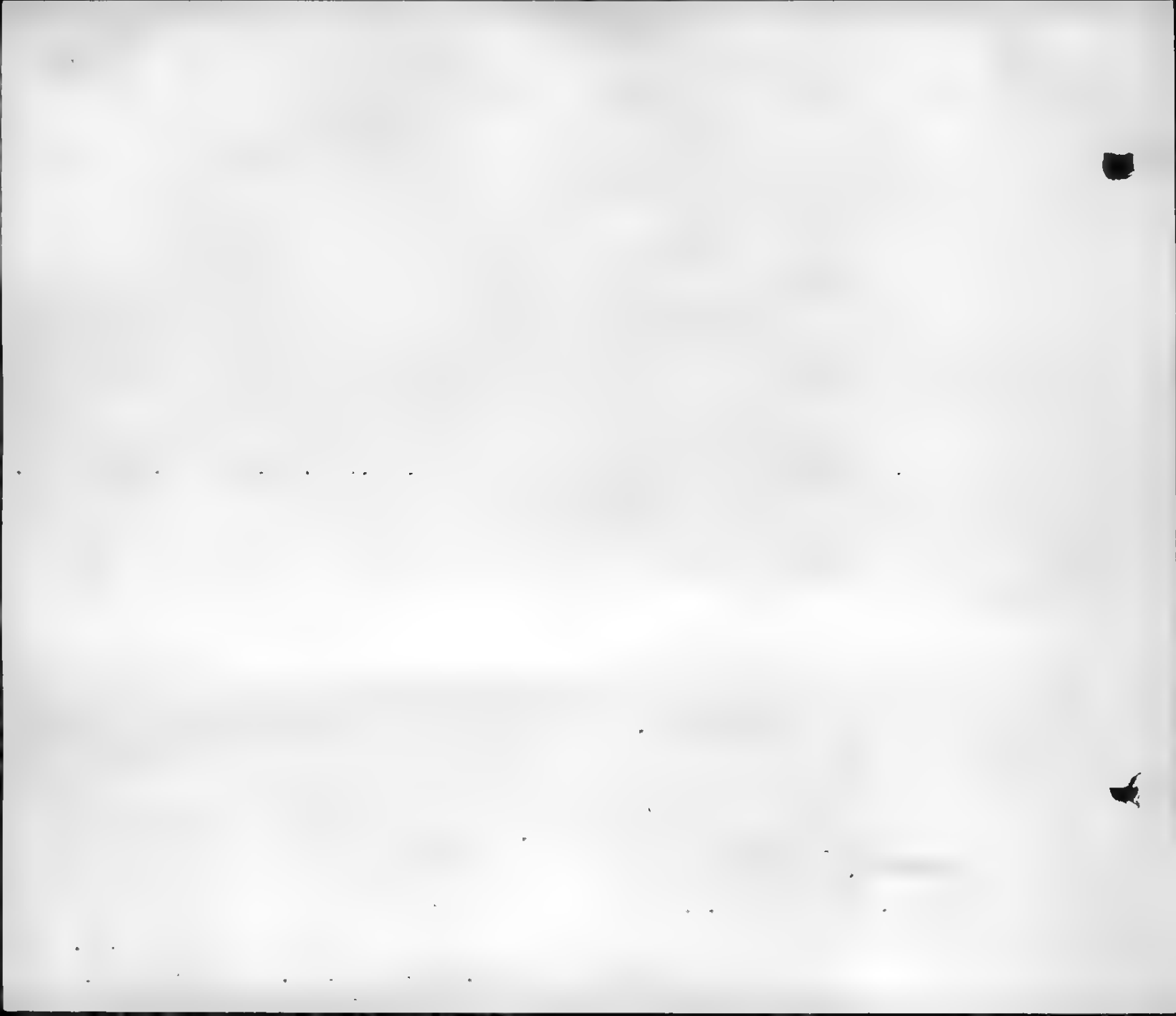
CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY 1	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Fort Howard				CITY (If outside corporate limits, write RURAL and give nearest town) OR Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		LENGTH OF STAY (in this place) 2 days		STREET ADDRESS (If rural give location) 1902 Tolson Avenue		53	
3. NAME OF DECEASED: (First) LAWRENCE (Middle) E. (Last) WENKER		4. DATE OF DEATH: (Month) October (Day) 9, (Year) 19 55					
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 7/10/02	
9. AGE last birthday 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John Wenker				14. MOTHER'S MAIDEN NAME: Fredericka Stegman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Y (If Yes, give war or dates of service) Korean				16. SOCIAL SECURITY NO. 705-10-4154		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
154X							
IMMEDIATE CAUSE (A) CARCINOMA OF RECTUM				2 YEARS			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2-55 (after)		19B. MAJOR FINDINGS OF OPERATION with colostomy		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 7, 1955, to Oct. 9, 1955 , and that death occurred at 1:35 PM , from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIFF, M.D.				ADDRESS M.D. VAH, FORT HOWARD, MARYLAND 10-10-55		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF OCT. 12, 1955		NAME OF CEMETERY OR CREMATORY Saint Stanislaus Cemetery		LOCATION (City, town, or county) (State) Baltimore (Dundalk), Md.	
DATE REC'D BY LOCAL REGISTRAR 10-11-55		REGISTRAR'S SIGNATURE W. W. Hedrick		24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Blight, Inc. 6009 Harford Rd. Baltimore 14, Maryland			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09575

9571

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u> LENGTH OF STAY (in this place) <u>180 yrs</u>		TOWN <u>Baltimore</u> 3701	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>423 N. Milton Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>ASIA</u> (Middle) <u>MINA</u> (Last) <u>WERNER</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>23</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 15, 1865</u>
9. AGE last birthday <u>90</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Farwell - Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis C. Ingram</u>		14. MOTHER'S MAIDEN NAME <u>Marston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. George Werner, 423 N. Milton Ave. Baltimore 24 Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 + Immediate cause

(a).....

Congestive Heart Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b).....

Coronary atherosclerosis with myocardial infarction

(c).....

Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept. 19, 1955 to Oct. 23, 1955, that I last saw the deceased

alive on Oct. 23, 1955, and that death occurred at 5:10 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>burial</u>	<u>Oct. 26, 1955</u>	<u>Parkwood Cemetery</u>	<u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>10/25/55</u>	<u>G. W. Hedrick</u>	<u>FLURY SANDER & SONS, INC.</u>	<u>Baltimore Md.</u>	

Ray P. Sander

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



9572

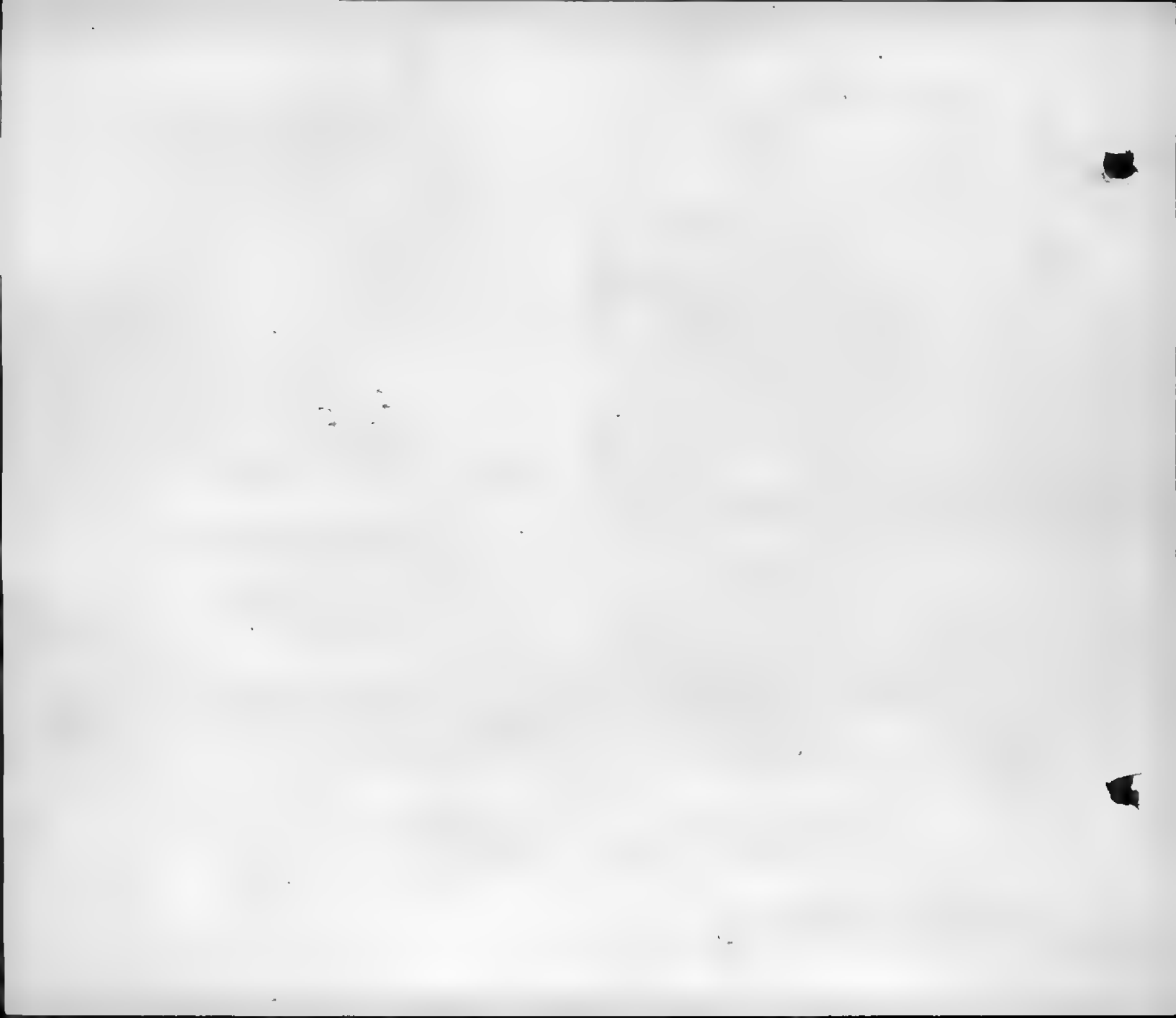
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ESSEX</u>		TOWN <u>ESSEX</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>RT. 1 BOX # 380</u>		<u>RT. 1 BOX # 380</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		DATE (Month) (Day) (Year)	
<u>FRANK JOSEPH WIECZYNSKI-WISE</u>		<u>OCT. 10 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>DEC. 27, 1907</u>
9. AGE last birthday: <u>47</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LAB. TECH.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>GENERAL ELECTRIC</u>	
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>FELIX WIECZYNSKI</u>		14. MOTHER'S MAIDEN NAME: <u>MOLLIE CIESLAK.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY NO.: <u>213-05-5327</u>	
17. INFORMANT & ADDRESS: <u>MARY C. WIECZYNSKI SAME.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE: <u>192 X</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Malignancy of Spine (adenocarcinoma)</u>		<u>2</u>	
(B) <u>Pylor-Nephritis</u>		<u>6 weeks</u>	
(C) <u>Decubitus Ulcers</u>		<u>4 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>July 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Malignancy of Spine</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Sept 1, 1955</u> , to <u>Oct 10 1955</u> that I last saw the deceased alive on <u>Oct 10, 1955</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>BURIAL</u>		DATE THEREOF: <u>10-14-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>SACRED HEART OF MARY GERMAN HILL RD.</u>		LOCATION (City, town, or county) (State): <u>MD.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>10-13-55</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>	
24. FUNERAL DIRECTOR: <u>[Signature]</u>		ADDRESS: <u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

9573

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Sorensen Nursing Home	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7912 Ruxway Rd. 4		STREET ADDRESS (If rural give location) 6523 Langdale Rd. #6	

3. NAME OF DECEASED: (First) (Middle) (Last) MARY VIRGINIA WILLIAMS			4. DATE (Month) (Day) (Year) OF DEATH Oct. 3, 19 55		
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Feb. 24, 1879	9. AGE last birthday 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rtd Housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home		11. BIRTHPLACE (State or foreign country): Md.	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME: -- Crispens		
14. MOTHER'S MAIDEN NAME: Unknown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS: Mr. Elmer H. Packie, Jr.-6523 Langdale Rd.		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) with dilation myocardial Hypertrophy		2 days
ANTECEDENT CAUSE (S) DUE TO myocarditis chronic		10 years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO General arteriosclerosis.		10 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Sept 24, 1955**, to **Oct. 3, 1955**, that I last saw the deceased alive on **Oct. 2, 1955**, and that death occurred at **8:00 P.M.** from the causes and on the date stated above.

SIGNATURE **James Graham Manton** ADDRESS **M.D. 516 Cathedral St** DATE SIGNED **10-5-1955**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 10/6/55	NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	LOCATION (City, town, or county) (State) Balto., Md.
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DATE REC'D BY LOCAL REGISTRAR 5-55	REGISTRAR'S SIGNATURE Dr. Redwood	24. FUNERAL DIRECTOR Wm. J. Lickner & Sons	ADDRESS Baltimore, Md.
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MARGIN RESERVED FOR BINDING



9574

CERTIFICATE OF DEATH

Reg. Dist. No. 44

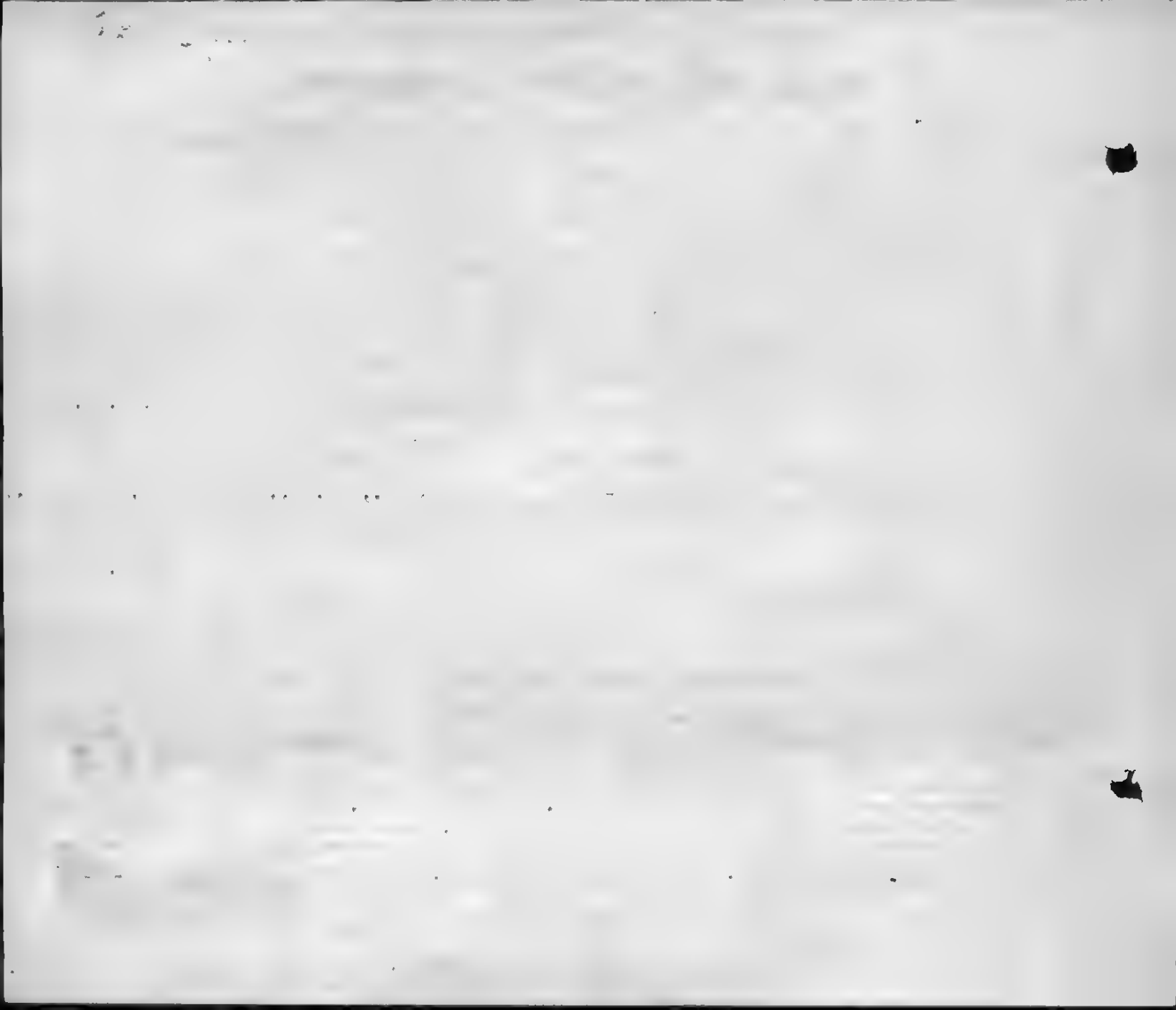
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>30 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>912 Shuter Street</u>			
3. NAME OF (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>GEORGE</u>		<u>G.</u>		<u>WILSON</u>		<u>October 26 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Single</u>	<u>6/13/11</u>	<u>41</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<u>Baltimore, Maryland</u>		<u>U. S. A.</u>
13. FATHER'S NAME <u>George L. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Virginia MN: Madison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service) <u>VV II</u>		16. SOCIAL SECURITY NO. <u>212-12-7580</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
2. IMMEDIATE CAUSE (A) <u>CACHEXIA</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>DIETARY INSUFFICIENCY (?)</u>						<u>MONTHS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<u>SEV. YEARS</u>	
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 26</u> , 19 <u>55</u> , to <u>Oct. 26</u> , 19 <u>55</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William E. VandeGriff, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>10-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE TIME OF <u>10/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Sawran L Farber</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Lee Mortuary, 802-04 Madison Ave.</u>		ADDRESS <u>Baltimore 1, Maryland</u>	
DATE <u>Oct. 29-55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



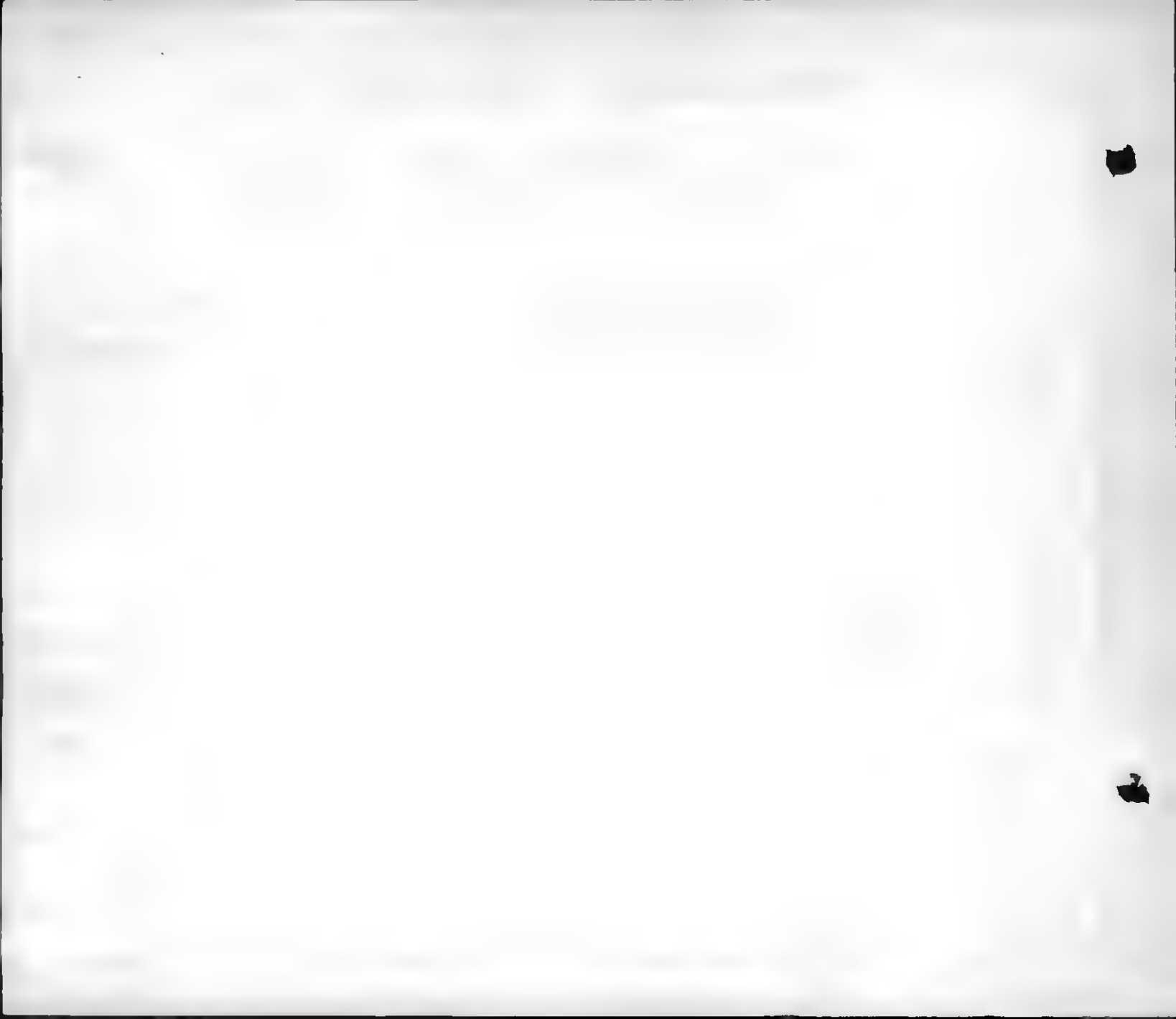
PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09573

9575 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) Harry Repp Worman				2. DATE OF DEATH Oct. 19, 1955	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Id. B. COUNTY Frederick	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2519 Cedar Drive				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore 50 yrs.				D. STREET ADDRESS (If rural, give location) 2519 Cedar Drive	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH June 13, 1882	9. AGE (in years, last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY Otis Elevator Co.		11. BIRTHPLACE (State or foreign country) Frederick, Md.	
13. FATHER'S NAME George Moses Worman				14. MOTHER'S MAIDEN NAME Amanda Jane Repp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-0410		17. INFORMANT ADDRESS H. Richard Worman - 2519 Cedar Drive.	
18. 141X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH Hypostatic Pneumonia Ca of tongue & Metastasis	
				INTERVAL BETWEEN ONSET AND DEATH 2 days 6 months	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9/20 , 19 55 , to 10/19 , 19 55 , that I last saw the deceased alive on 10/19 , 19 55 , and that death occurred at 5:00 m., from the causes and on the date stated above.					
23A. SIGNATURE Joseph J. Lawkaitis		23B. ADDRESS 679 Washington Blvd		23C. DATE SIGNED 10/19/55	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 10/22/1955		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Frederick, Md.		25. FUNERAL DIRECTOR Edmund C. Cunniff		ADDRESS Frederick, Md.	
DATE RECEIVED BY LOCAL REGISTRAR 10-20-55		REGISTRAR'S SIGNATURE Alfred L. ...			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9576				09580 Reg. Dist.			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 2							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY Anna Arundel			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville 28		LENGTH OF STAY (in this place) 1 yr 8 days		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Annapolis		02 X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural, give location) RFD #1			
3. NAME OF DECEASED: (First) Brice		(Middle) John		(Last) WORTHINGTON		4. DATE OF DEATH (Month) (Day) (Year) October 22, 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: Apr. 17, 1864		9. AGE last birthday: 91 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Carpenter & Farmer			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: B. John Worthington				14. MOTHER'S MAIDEN NAME: Mathilda Pue			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Records: Spring Grove State Hospital		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Terminal bronchopneumonia							1 week
DUE TO							
Antecedent cause(s) (b) Senility							2
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) Fracture left femur							3 weeks
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc., INJURY Hospital		21c. (City or town) (County) (State) Catonsville Baltimore Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10/1/55 ? M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell from bed			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Geo. S. M. Kieffer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/22/55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL		DATE THEREOF: 10/24/55		NAME OF CEMETERY OR CREMATORY: St Pauls		LOCATION (City, town, or county) (State): Crownsville Md.	
DATE REC'D BY LOCAL REG. Oct. 24		REGISTRAR'S SIGNATURE: [Signature]		24. FUNERAL DIRECTOR: Harry Arthur M. Taylor & Sons ADDRESS: Annapolis, Md.			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9577
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

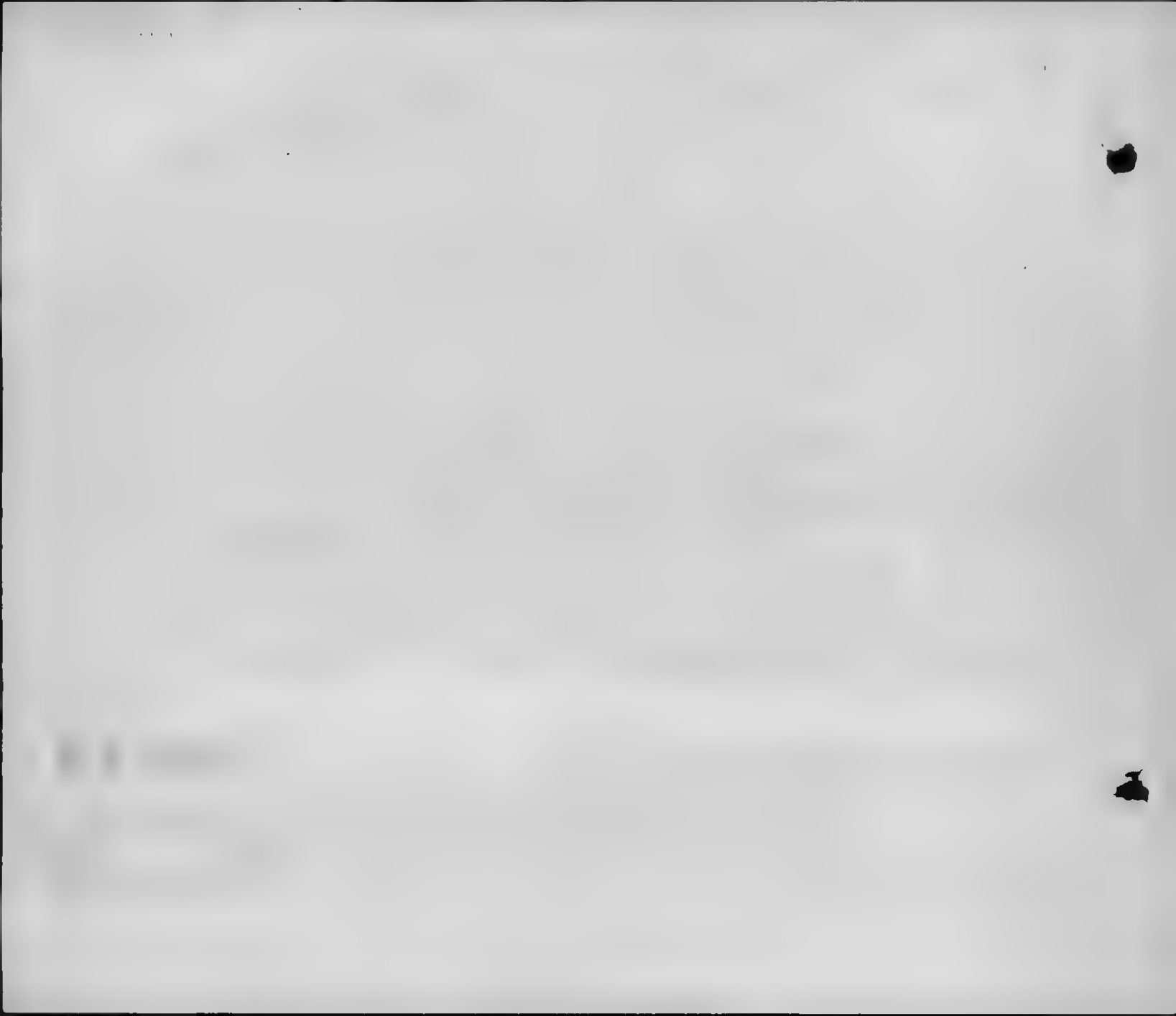
09581

Reg. Dist.

No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN WOODLAWN</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>OR TOWN 6900 CARL AVE</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6900 CARL AVE</u>		STREET ADDRESS (If rural, give location) <u>WOODLAWN, MD.</u>	<u>1</u>
3. NAME OF DECEASED: (Type or Print) <u>JOSEPH G. YAEGER</u>		4. DATE OF DEATH <u>OCT. 29 19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 27, 1903</u>
9. AGE last birthday: <u>52</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>MD.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>GEORGE J. YAEGER</u>		14. MOTHER'S MAIDEN NAME: <u>ELIZ. M. SCHWARTZKOPF</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Mrs. J. S. Yaege, 6900 Carl Ave</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>420.1</u> Antecedent cause(s) (b) <u>Cornary Thrombosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Joseph Kieffer</u> 10:10 hrs on <u>11-2-55</u> CHIEF MEDICAL EXAMINER <u>W.D.</u> DEPUTY MEDICAL EXAMINER <u>W.D.</u> ASSISTANT MEDICAL EXAM. <u>W.D.</u> DATE SIGNED <u>10/31/55</u>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>buried</u>	DATE THEREOF: <u>11-2-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Catholic Cem.</u>
LOCATION (City, town, or county): <u>Balto</u>	(State): <u>MD.</u>	
DATE REC'D BY LOCAL REG. <u>11-1-55</u>	REGISTRAR'S SIGNATURE: <u>W.D.</u>	24. FUNERAL DIRECTOR: <u>W.D.</u> ADDRESS: <u>W.D.</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 189582
9578 CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
52 TOWN Catonsville		18yr2mos17days		TOWN Baltimore		301-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 Spring Grove State Hospital				2448 West North Avenue			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH:	
Anna Giannone Yakel				October 3, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	3-10-1899	56 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Domestic					Pennsylvania		USA
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Jack Morrison				Amanda Morrison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		Unknown		Records Spring Grove State Hospital			
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinoma of Cervix with metastases							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1- , 19 55 to 10-3- , 19 55 that I last saw the deceased alive on 10-3- , 19 55 , and that death occurred at 2:00P M , from the causes and on the date stated above.							
SIGNATURE Sheila Wachler				DATE SIGNED 10-3-55			
ADDRESS Spring Grove State Hospital Catonsville 28, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/5/55		Cathedral		Balt., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10/4/55		V.E. Harvey		Mac Nabholz		28	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 6 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09583

9579

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Parkville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parkville X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 2941 Manns Ave.		STREET ADDRESS (If rural give location) 2941 Manns Ave.	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print) VIOLA AGNES ZIMMERMAN		OF DEATH: Oct. 4, 19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
female	white	married	Dec. 4, 1884
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
Clerk		Motor Registration	Maryland
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
John William Harvey Burgeon		Emma Virginia Frock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no			
17. INFORMANT & ADDRESS:			
Mr. Leo A. Zimmerman - 2941 Manns Ave.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
155X		
IMMEDIATE CAUSE		
(A) DUE TO		
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 4, 1955 , to Oct 4, 1955 , that I last saw the deceased alive on Oct 4, 1955 , and that death occurred at 7 P. M. from the causes and on the date stated above.					
SIGNATURE Frank E. Harik, Jr.		ADDRESS 9005 Harford Rd.		DATE SIGNED 10/6/55	
M. D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		10/7/55		Druid Ridge Cem.	
LOCATION (City, town, or county) (State)					
Pikesville, Md.					
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
10-6-55		Am. H. Harik, Jr.		Am. J. Lichner & Sons - Balto 17	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

